VOA Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

STELARA®(USTEKINUMAB) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to (757) 466-1128

☐ **NEW PATIENT OR**
☐ **CHANGE ORDER:** ◯ **Drug Change** ◯ **Dose Change** ◯ **Interval Change**

Patient Name:	Phone:	Date of Birth:
Address:		
Allergies:		
Height: inches cm	Weight: lbs kg	

CLINICAL INFORMATION

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose? ☐ Yes
☐ No – date of next dose due: _____

Treatments – Tried and Failed:

TB Status: ☐ PPD (negative) – date: ☐ Active TB ☐ Unknown
☐ Last chest X-ray – date: ☐ Other: _____
☐ Past positive TB infection, course taken: _____

STELARA® (Ustekinumab) PRESCRIPTION

Stelara® (Ustekinumab) refill as directed x 1 year

Initial Dose: ☐ IV: Infuse over at least 1 hour once (check one): ☐ 260mg (up to 55kg) ☐ 390mg (>55kg to 85kg) ☐ 520mg (>85kg)
☐ SUBQ: Nurse to inject _____ mg SUBQ initially and repeat 4 weeks later.

Maintenance Dose: ☐ Nurse to inject _____ mg SUBQ every _____ weeks.

Next Dose Due Date: _____

ANCILLARY ORDERS

Pre - Medication Orders:

☐ Acetaminophen 650mg PO 30 minutes before infusion.
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

PRESCRIBER INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Address:		**NPI:**
City, State:	**Zip:**	**Office Contact:**