HONORHEALTH®

USTEKINUMAB
(Stelara)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status ☐ New Order ☐ Renewal ☐ Dose or Frequency Change

Diagnosis
- ☐ Crohn's disease, moderate to severe
- ☐ Ulcerative colitis
- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Other:

Diagnosis Code: _____

Required Information (Please include lab result documents)

Allergies:

Negative Quantiferon TB or T-spot or chest x-ray	Date:	Weight: _____
Diagnostic Hepatitis B Panel	Date:	
Coccidioides Screen/Panel	Date:	Height: _____
CBC, CMP	Date:	

Labs ☐ CBC, CMP every _____ ☐ Other:

Stelara

Induction: (dose is weight based)
- ☐ ≤ 55kg: 260mg **IV** as a single dose
- ☐ > 55kg to 85 kg: 390mg **IV** as a single dose
- ☐ > 85kg: 520mg **IV** as a single dose
- ☐ Other:

Maintenance:
- ☐ 90mg **SQ** every 8 weeks
- ☐ Other:

- ☐ < 100kg: 45mg **SQ** at 0 and 4 weeks, and then every 12 weeks thereafter
- ☐ > 100kg: 90mg **SQ** at 0 and 4 weeks, and then every 12 weeks thereafter
- ☐ 45mg **SQ** at 0 and 4 weeks, and then every 12 weeks thereafter
- ☐ Other:

Infusion Reaction Medications Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation
- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: