vitalcare of ROANOKE

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STELARA (USTEKINUMAB)
MEDICATION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ TB documentation
☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Plaque Psoriasis (ICD-10: _____) ☐ Psoriatic Arthritis (ICD-10: _____)

Pt. Weight _____ kg

Stelara: ☐ Patients weighing < 100kg, 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks
☐ Patients weighing > 100kg, 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks
☐ Other:_____

Diagnosis: ☐ Crohn's (ICD-10: _____)

Pt. Weight _____ kg

Stelara Initial Infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose
☐ 55kg to 85kg 390 mg IV over 1 hour x 1 dose

Stelara Maintenance: ☐ >85kg 520 mg IV over 1 hour x 1 dose
☐ 90 mg SQ 8 weeks after initial infusion and then refill every 8 weeks for 1 year for a total of 6 refills

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	