Stelara (ustekinumab)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ L40.50 Psoriatic Arthritis

☐ L40.0 Plaque Psoriasis

☐ K50.90 Crohn's/Pediatric Crohn's Disease

☐ K51.90 Ulcerative Colitis/Pediatric UC

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg / ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mgIV ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____.

SPECIAL INSTRUCTIONS

MEDICATION ORDER

Stelara (ustekinumab) - **IV infusion**

Dose: ☐ 260mg IV ☐ 520mg IV ☐ 390mg IV

Frequency: ☐ once (week 0)

Stelara (ustekinumab) **- SC Injection**

Dose: ☐ 0.75mg/kg ☐ 90mg ☐ 45mg

Frequency:

☐ Give at week 0, 4 then every 12 weeks

☐ Give every 12 weeks

☐ Give at week 8 (after IV infusion) then every 8 weeks thereafter

☐ Give every 8 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**