vitalcare of LITTLE ROCK
Fountains Infusion Center
15200 Chenal Pkwy. Suite 300 Little Rock AR
Phone: 501-451-6080 Fax:501-451-6081

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: _____) ☐ Ulcerative Colitis (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
☐ >85kg 520 mg IV over 1 hour x 1 dose

Stelara Maintenance: ☐ 90 mg SQ injection every _____ weeks x _____ refills
☐ Other_____

Additional Instructions:

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
Lab orders: _____ Frequency: _____

Premedication Orders: ☐ Tylenol 650mg ☐ Benadryl 25mg PO ☐ OTHER _____

Additional Orders_____

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