Ustekinumab (Stelara, Yesintek)

Provider Order Form rev. 7/18/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Crohn's Disease: Ulcerative Colitis:

Plaque Psoriasis: Psoriatic Arthritis:

REQUIRED INFORMATION *(Choose one)*

☐ Patient will self-administer subcutaneous medication ***(Referring provider will coordinate with specialty pharmacy)***

☐ Patient would like in-office injection medication ***(NOTE:** some insurance providers may require attestation from provider stating patient cannot self-administer with reason why such as needle phobia or low dexterity.)*

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Infuse Ustekinumab (Stelara) OR Ustekinumab biosimilar as required by patient's insurance.

☐ Administer this Ustekinumab product: _____

For Crohn's/Ulcerative Colitis:

☐ Induction: Administer Ustekinumab mixed in 250ml 0.9% NS over 1 hour on week 0, one time dose only:

- ☐ 260mg IV x1 dose (weight of up to 55kg)
- ☐ 390mg IV x1 dose (weight of 55kg to 85kg)
- ☐ 520mg IV x1 dose (weight greater than 85kg)

☐ Maintenance: Administer Ustekinumab 90mg subcutaneously every 8 weeks

For Plaque Psoriasis/Psoriatic Arthritis:

☐ Induction: Administer Ustekinumab subcutaneously on week 0 and week 4:

- ☐ 45mg subcutaneously (weight less than 100kg)
- ☐ 90mg subcutaneously (weight greater than 100kg)

☐ Maintenance: Administer Ustekinumab 45mg subcutaneously every 12 weeks (weight less than 100kg)

☐ Maintenance: Administer Ustekinumab 90mg subcutaneously every 12 weeks (weight greater than 100kg)

IV DOSE PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of illness/active infection or cough, night sweats, unexplained weight loss
- Planned/recent surgical procedures, recent live vaccinations, or neurological changes

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Colonoscopy, reason patient is unable to self-inject subcutaneous dose.

Required Labs: TB, Hep B ESR, CRP, for RA: RF, CCP, for CD/UC: cal pro

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.