

Ustekinumab (Stelara, Yesintek, Otulfi)

Provider Order Form rev. 3/26/2026

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name:	DOB:	Patient Phone:
Patient Address:	Patient Email:	
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg): Height (in/cm):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> 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: This option is only available for Stelara and not available for any Stelara Biosimilar. 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 Stelara 90mg subcutaneously every 8 weeks

For Plaque Psoriasis/Psoriatic Arthritis: (Stelara only)

- Induction: Administer Stelara subcutaneously on week 0 and week 4:
 - 45mg subcutaneously (weight less than 100kg)
 - 90mg subcutaneously (weight greater than 100kg)
- Maintenance: Administer Stelara 45mg subcutaneously every 12 weeks (weight less than 100kg)
- Maintenance: Administer Stelara 90mg subcutaneously every 12 weeks (weight greater than 100kg)

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.

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