Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Stelara (ustekinumab) ADULT DOSING

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)	
☐ Richmond	☐ Prince George

* * If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required * *

DIAGNOSIS AND ICD-10 CODE			
☐ Moderate to Severe Ulcerative Colitis	K51.90	☐ Psoriatic Arthritis	L40.50
☐ Moderate to Severe Crohn's Disease	K50.90	☐ Plaque Psoriasis	L40.0
☐ Other: ___________________________	ICD10 ____		

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Negative QuantiFERON Gold TB Test or Skin PPD	☐ HBV Panel results
☐ Patient currently receiving same therapy at _________________________________ Last dose: _____________________	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS- ADULT DOSING**	
Initial Dosing (for Gastroenterology)	☐ Stelara (<55kg) 260mg infuse IV over 1 hour x 1 dose
	☐ Stelara (55kg to 85kg) 390mg infuse IV over 1 hour x 1 dose
	☐ Stelara (>85kg) 520mg infuse IV over 1 hour x 1 dose
Maintenance Dosing **	☐ Stelara 90mg administer SubQ every 8 weeks
Initial Dosing (for Rheumatology)**	☐ Stelara 45mg (< 100kg) administer SubQ at week 0, 4, then every 12 weeks
	☐ Stelara 90mg (> 100kg) administer SubQ at week 0, 4, then every 12 weeks
Maintenance Dosing **	☐ Stelara 45mg (< 100kg) administer SubQ every 12 weeks
	☐ Stelara 90mg (> 100kg) administer SubQ every 12 weeks
Patient Weight: _______ kg or _______ lb	Patient Height: ______ in
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _______________	

**If prescriber chooses to provide a Subcutaneous order to Infusion Solutions, we will ask insurance provider IF Infusion Solutions can provide. However, many carriers require Speciality Pharmacy Networks for the SubQ injections and Infusion Soltutions is UNABLE to assist. Prescriber will be notified promptly if this is the case.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion and/or injection
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion and/or injection
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ Other PreMed or Lab Order with frequency: ____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.