

Stelara Injection Order

(Ustekinumab)



InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:**

- Demographics Insurance Information Current CBC & CMP
 H & P Relevant to Diagnosis Current Medications
 TB Results Colonoscopy & Pathology Report

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

TB TEST

Result: _____ Test Date: _____ Copy Attached

STELAR INJECTION (USTEKINUMAB) DOSAGE

Date of Last Treatment, If Continuation: _____

Stelara Injection 45 mg / 0.5 mL

Psoriatic Arthritis or Plaque Psoriasis

**Loading dose at weeks 0 and 4,
then every 12 weeks, subcutaneous injection.**

45 mg OR 90 mg

Crohn's Disease

Maintenance Dose Only:

90 mg subcutaneous injection
**8 weeks after initial IV dose
then every 8 weeks.**