Stelara Injection Order
(Ustekinumab)

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ______ / ______ / __________ Treatment Location: ______________________________

***Please fax a copy of the following patient information:**
- ☐ Demographics
- ☐ Insurance Information
- ☐ Current Lab Results
- ☐ H & P Relevant to Diagnosis
- ☐ Current Medications
- ☐ TB Results

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: ______________________________

TB TEST

Result: ____________________ Test Date: ______ / ______ / __________ ☐ Copy Attached

STELAR INJECTION (USTEKINUMAB) DOSAGE

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.