USTEKINUMAB

(Including Stelara and biosimilars)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Med List • Tried/Failed Therapies • Neg TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications (CD)
☐ K50.019 Crohn's disease of small intestine with unsp comp (CD)
☐ K50.10 Crohn's disease of large intestine without complications (CD)
☐ K50.90 Crohn's disease, unspecified, without complications (CD)
☐ K51.00 Ulcerative (chronic) pancolitis without complications (UC)
☐ K51.90 Ulcerative colitis, unspecified, w/o complications (UC)
☐ L40.5 Psoriatic Arthritis (PsA)
☐ L40.9 Plaque Psoriasis (Ps)
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol: No recommended standard pre-meds for Stelara

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*Biosimilar may be used according to payer guidelines

*To prohibit auto-substitution, please indicate specific brand required:_____

Ulcerative Colitis (UC) – or – Crohn's Disease (CD)

Induction Doses (to be administered in infusion clinic):
- ☐ Weight <55kg: Stelara 260mg IV once
- ☐ Weight 55kg: Stelara 390mg IV once
- ☐ Weight >85kg: Stelara 520mg IV once

Maintenance Doses:
- ☐ Infusion clinic will coordinate with SP for self-administration or administration in-clinic as payor dictates: Stelara 90mg subQ every 8 weeks after induction dose.
- ☐ Provider's office will coordinate initial maintenance dose from SP.

Plaque Psoriasis (Ps) – or – Psoriatic Arthritis (PsA)
- ☐ Weight ≤ 100kg: Stelara 45mg subQ at Weeks 0, 4, and every 12 weeks thereafter
- ☐ Weight > 100kg: Stelara 90mg subQ at Weeks 0, 4, and every 12 weeks thereafter

*Infusion clinic will coordinate initial dose from Specialty Pharmacy

☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals