

USTEKINUMAB

(Including Stelara and biosimilars: Wezlana, Yesintek, Selarsdi, Pyzchiva, Steqeyma)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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

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

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 (Wezlana, Yesintek, Selarsdi, Pyzchiva, Steqeyma) 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____

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