

STELARA® (ustekinumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Hepatitis B Status Results
 Clinical/Progress Notes Supporting Dx TB test results

Primary Diagnosis

-  ICD-10 Code (required): _____ Ulcerative colitis
 Plaque psoriasis Crohn's disease
 Psoriatic arthritis Other: _____

Pre-Medication

- Per violet health protocol: No standard recommended premedications for Stelara  Other: _____

Therapy Administration

Plaque Psoriasis:

- Weight ≤ 100kg:**
 Stelara 45 mg SubQ at week 0, week 4, then every 12 weeks thereafter
 Weight >100 kg:
 Stelara 90 mg SubQ at week 0, week 4, then every 12 weeks thereafter

Psoriatic Arthritis:

- Stelara 45 mg SubQ at week 0, week 4, then every 12 weeks thereafter

Crohn's Disease & Ulcerative Colitis

Induction Dosing:

- Weight <55 kg: Stelara 260 mg IV x 1 dose
 Weight 55-85 kg: Stelara 390 mg IV x 1 dose
 Weight >85 kg: Stelara 520 mg IV x 1 dose

Maintenance Dosing

(starts 8 weeks after IV dose):

- Stelara 90 mg SubQ every 8 weeks

Refills:

- x 1 year Other: _____

 Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/ protocol for policy) Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) **Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box**
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration. RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____