FLOMED INFUSION

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STELARA (ustekinumab)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____
Required Labs: _____

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: _____

STELARA (ustekinumab) ORDERS

Plaque Psoriasis
☐ Patients weighing <100kg (220lb), 45mg SubQ intially, and 4 weeks later followed by 45mg every 12 weeks.
☐ Patients weighing >100kg (220lb), 90mg SubQ intially, and 4 weeks later followed by 90mg every 12 weeks.

Crohn's Disease:
☐ <55kg (121lb) 260mg IV over 1 hour
☐ 55kg to 85kg (121lb - 187lb) 390mg IV over 1 hour
☐ > 85kg (121lb - 187lb) 520mg IV over 1 hour

Maintenance Dose:
☐ 90mg SQ 8 weeks after initial dose and then every 8 weeks for a year.

Additional Orders/Comments: _____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____