# STELARA
(ustekinumab)

FLOURISH™ HEALTH GROUP

## 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

**Ulcerative Colitis (UC) – or – Crohn's Disease (CD)**
Induction Doses (to be administered in infusion clinic):
☐ Stelara 260mg <55kg IV once
☐ Stelara 390mg 55-85kg IV once
☐ Stelara 520mg >85kg 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)**
☐ Stelara 45mg ≤ 100kg / 90mg > 100kg 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 Flourish Health Group's protocol (See flourishhealth.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 Flourish Health Group's protocol (See flourishhealth.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