



Specialty Infusion Apothecary & Wellness Spa

INFUSION ORDERS-STELARA (USTEKINUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 Code: L40.52
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Plaque Psoriasis Dosing	<input type="checkbox"/> Stelara 45mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) <input type="checkbox"/> Stelara 90mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight > 100kg)
Psoriatic Arthritis Dosing	<input type="checkbox"/> Stelara 45mg SubQ at Week 0, 4, then every 12 weeks thereafter <input type="checkbox"/> Other: Stelara _____ mg SubQ _____
Crohn's Disease and Ulcerative Colitis Dosing	Initial IV dose (choose one): _____ <input type="checkbox"/> Stelara 260mg IV x1 for Weight <55kg <input type="checkbox"/> Stelara 390mg IV x1 for Weight 55-85kg <input type="checkbox"/> Stelara 520mg IV x1 for Weight >85kg <u>Maintenance Dosing (will start 8 weeks after IV dose, when applicable):</u> <input type="checkbox"/> Stelara 90mg SubQ every 8 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Contact us with questions at: info@siainfusions.com or call (561) 955-7079

Fax completed form and all documentation to **(561) 617-5360**

All information contained in this form is strictly confidential and will become part of the patient's medical record.