

Stelara (ustekinumab)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
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PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
	Next Due Date (if applicable):		

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

- L40.50 Psoriatic Arthritis
- L40.0 Plaque Psoriasis
- K50.90 Crohn's/Pediatric Crohn's Disease
- K51.90 Ulcerative Colitis/Pediatric UC
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg / PO IV
- methylprednisolone (Solu-Medrol) 40mgIV 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

Stelara (ustekinumab) - IV infusion

Dose: 260mg IV 520mg IV
390mg IV

Frequency: once (week 0)

Stelara (ustekinumab) - SC Injection

Dose: 0.75mg/kg 90mg
45mg

Frequency:

Give at week 0, 4 then every 12 weeks

Give every 12 weeks

Give at week 8 (after IV infusion) then every 8 weeks thereafter

Give every 8 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order