MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

STELARA (USTEKINUMAB)

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

REFERRAL STATUS
❑ New Referral ❑ Dose or Frequency Change ❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: ❑ Montgomery ❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
❑ Active Psoriatic Arthritis	ICD 10 Code: L40.52
❑ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
❑ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
❑ Other:	ICD10 Code:

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider	❑ Clinical/Progress notes supporting primary diagnosis
❑ Patient demographics AND insurance information	❑ Labs and Tests supporting primary diagnosis
❑ Hepatitis B Test Results: HBsAg & HepB Core w/reflex IgG and IgM	❑ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS	
Plaque Psoriasis Dosing	❑ Stelara 45mg subQ at week 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) ❑ Stelara 90mg subQ at week 0, 4, then every 12 weeks thereafter (Weight > 100kg)
Psoriatic Arthritis Dosing	❑ Stelara 45mg subQ at Week 0, 4, then every 12 weeks thereafter ❑ Other: Stelara _____ mg sub-Q _____
Crohn's Disease and Ulcerative Colitis Dosing	Initial IV dose (choose one): ❑ Stelara 260mg IV x1 for Weight <55kg ❑ Stelara 390mg IV x1 for Weight 55-85kg ❑ Stelara 520mg IV x1 for Weight >85kg Maintenance Dosing (will start 8 weeks after IV dose, when applicable): ❑ Stelara 90mg subQ every 8 weeks

Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PREMEDICATIONS
✓ Acetaminophen 1000mg PO prior to Stelara infusion
✓ Diphenhydramine 25mg IVP prior to Stelara infusion
❑ Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207

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