INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ustekinumab *Stelara & biosimilars*

- ☐ Selardsi (ustekinumab-aekn)
- ☐ Steqeyma (ustekinumab-stba)
- ☐ Yesintek (ustekinumab-kfce)
- ☐ Stelara (ustekinumab)
- ☐ Otulfi (ustekinumab-aauz)
- ☐ Wezlana (ustekinumab-auub)
- ☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

- ☐ Psoriatic Arthritis, ICD 10: L40.
- ☐ Crohn's Disease, ICD 10: K50.
- ☐ Psoriasis, ICD 10: L40.
- ☐ Ulcerative Colitis, ICD 10: K51.
- ☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

- ☐ Negative TB
- ☐ Office/progress notes
- ☐ Demographics
- ☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

- ☐ Acetaminophen (Tylenol) 500 mg PO
- ☐ Famotidine 20 mg IV
- ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ☐ Diphenhydramine (Benadryl) 25 mg PO
- ☐ Cetirizine (Zyrtec) 10 mg PO
- ☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Ustekinumab	☐ 260 mg ☐ 390 mg ☐ 520 mg	IV	x 1 dose
	☐ 45 mg ☐ 90 mg	Subcutaneous inj.	☐ 8 weeks after initial IV dose then every 8 weeks ☐ Every 8 weeks

x1 IV infusion needs to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____