Ustekinumab (Stelara, Yesintek)

Provider Order Form rev. 7/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Crohn's Disease: Ulcerative Colitis:

Plaque Psoriasis: Psoriatic Arthritis:

REQUIRED INFORMATION *(Choose one)*

☐ Patient will self-administer subcutaneous medication ***(Referring provider will coordinate with specialty pharmacy)***

☐ Patient would like in-office injection medication *(**NOTE:** some insurance providers may require attestation from provider stating patient cannot self-administer with reason why such as needle phobia or low dexterity.)*

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Infuse Ustekinumab (Stelara) OR Ustekinumab biosimilar as required by patient's insurance.

☐ Administer this Ustekinumab product: _____

For Crohn's/Ulcerative Colitis:

☐ Induction: Administer Ustekinumab mixed in 250ml 0.9% NS over 1 hour on week 0, one time dose only:

- ☐ 260mg IV x1 dose (weight of up to 55kg)
- ☐ 390mg IV x1 dose (weight of 55kg to 85kg)
- ☐ 520mg IV x1 dose (weight greater than 85kg)

☐ Maintenance: Administer Ustekinumab 90mg subcutaneously every 8 weeks

For Plaque Psoriasis/Psoriatic Arthritis:

☐ Induction: Administer Ustekinumab subcutaneously on week 0 and week 4:

- ☐ 45mg subcutaneously (weight less than 100kg)
- ☐ 90mg subcutaneously (weight greater than 100kg)

☐ Maintenance: Administer Ustekinumab 45mg subcutaneously every 12 weeks (weight less than 100kg)

☐ Maintenance: Administer Ustekinumab 90mg subcutaneously every 12 weeks (weight greater than 100kg)

LABORATORY ORDERS

☐ Other: _____

IV DOSE PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of illness/active infection or cough, night sweats, unexplained weight loss
- Planned/recent surgical procedures, recent live vaccinations, or neurological changes

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Colonoscopy, reason patient is unable to self-inject subcutaneous dose.

Required Labs: TB, Hep B ESR, CRP, for RA: RF, CCP, for CD/UC: cal pro

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.