COMMUNITY HEALTH INTERVENTIONS
SPECIALTY CLINIC

Community Health Interventions Specialty Clinic

INFUSION ORDERS-STELARA (USTEKINUMAB)

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

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

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:____	ICD 10 Code: ________________________

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ TB Test Results	☐ 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	☐ Stelara 45mg SubQ at Wk 0, 4, then every 12 weeks thereafter (Weight ≤ 100kg) ☐ Stelara 90mg SubQ at Wk 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 SubQ ____________________________
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

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

Contact us with questions at: jeff@eastoninfusion.com or call 728-777-5546

Fax completed form and all documentation to **(561) 709-8626**

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