



477 W. Horton Rd.
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight (kg): _____

IV Access: _____

Allergies: _____

Stelara (for Psoriasis) Order Form

◆ **Orders are initiated unless crossed out by provider.**

Check box to initiate order.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

<u>Diagnoses:</u>	<input type="checkbox"/> Plaque Psoriasis	ICD-10: L40.0
	<input type="checkbox"/> Other: _____	ICD-10: _____
<u>TB History:</u>	Date of last PPD test: _____	Result: _____
<u>Medication Orders:</u>		
◆ Stelara (ustekinumab):		
<input type="checkbox"/> Weight ≤100kg: Stelara 45mg SubQ initially, in 4 weeks, and every 12 weeks thereafter		
<input type="checkbox"/> Weight >100kg: Stelara 90mg SubQ initially, in 4 weeks, and every 12 weeks thereafter		
<input type="checkbox"/> Other: _____		
◆ Infusion Reaction Management per Infusion Solutions Protocol as needed.		
<u>Nursing Orders:</u>		
◆ RN to administer SubQ injections, and train patient to self-inject if deemed clinically appropriate.		
<input type="checkbox"/> Other: _____		

<u>Labs:</u>		
<input type="checkbox"/>	_____	every _____
<input type="checkbox"/>	_____	every _____
<input type="checkbox"/>	_____	every _____

Prescriber Signature

Date

Please Print Name