Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

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.

Diagnoses:
☐ Plaque Psoriasis — ICD-10: L40.0
☐ Other: _____ ICD-10: _____

TB History: Date of last PPD test: _____ Result: _____

Medication Orders:

- Stelara (ustekinumab):

☐ Weight ≤100kg: Stelara 45mg SubQ initially, in 4 weeks, and every 12 weeks thereafter

☐ Weight >100kg: Stelara 90mg SubQ initially, in 4 weeks, and every 12 weeks thereafter

☐ Other: _____

- Infusion Reaction Management per Infusion Solutions Protocol as needed.

Nursing Orders:

- RN to administer SubQ injections, and train patient to self-inject if deemed clinically appropriate.

☐ Other: _____

_____

Labs:

☐ _____ every _____

☐ _____ every _____

☐ _____ every _____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name