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: _____

IV Access:_____ Height:_____

Allergies: _____

Stelara (for Psoriasis) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

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

KEY: ◆ Orders are initiated unless crossed out by provider. **❑ Check to initiate order.**