Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Stelara® (ustekinumab) Plant of Treatment for Rheumatology & Dermatology

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	L40.50 - Arthropathic psoriasis, unspecified	☐	L40.0 - Psoriasis vulgaris
☐	L40.59 - Other psoriatic arthropathy	☐	L40.9 - Psoriasis, unspecified
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ustekinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

DOSE/FREQUENCY:

☐ Stelara® (ustekinumab) 45mg subcutaneous injection
- ☐ Induction: Injection at 0 week, 4 week, and then every 12 weeks
- ☐ Maintenance: Injection every 12 weeks
- ☐ Maintenance: Every ____ weeks

☐ Stelara® (ustekinumab) 90mg subcutaneous injection
- ☐ Induction: Injection at 0 week, 4 week, and then every 12 weeks
- ☐ Maintenance: Injection every 12 weeks
- ☐ Maintenance: Every ____ weeks

***Note: 90mg dose only suggested for patients greater than 100kg with psoriasis or psoriatic arthritis with co-existent moderate to severe plaque psoriasis.**

Administer as a subcutaneous injection to the upper arm, gluteal region, thigh, or abdomen

SPECIAL ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	