LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

# Stelara® (ustekinumab) SUBCUTANEOUS Injection Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ (ICD-10) Plaque psoriasis _____ (ICD-10) Psoriatic arthritis

_____ (ICD-10) Other _____

Nursing Orders:

☑ Hold treatment and notify provider for:
- Signs or symptoms of illness or active infection
- Cough, night sweats, unexplained weight loss
- Planned/recent surgical procedures
- Neurological changes
- Recent live vaccinations

Stelara ☐ 45 mg/0.5 ml (up to 100 kg) Patient weight: _____ kg

Stelara ☐ 90 mg/ml (greater than 100 kg)

Administer SUBCUTANEOUSLY in the upper arm, abdomen or upper thigh. Frequency:

☐ Induction dosing: Week 0, Week 4, then every 12 weeks

☐ Maintenance dosing: Every 12 weeks ☐ Other: _____

Observation Period:

☑ Following *initial* Stelara treatment, observe patient for 15 minutes for hypersensitivity. Patients who have previously tolerated Stelara do not require observation period.

☑ If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.