Local Infusion

MYLOCALINFUSION.COM

USTEKINUMAB (AND BIOSIMILAR) ORDER FORM

❑ Selardsi (ustekinumab-aekn) ❑ Yesintek (ustekinumab-kfce) ❑ Otulfi (ustekinumab-aauz)
❑ Steqeyma (ustekinumab-stba) ❑ Stelara (ustekinumab) ❑ Wezlana (ustekinumab-auub)
❑ **Dispense As Written (DAW)**
Will substitute for biosimilar or reference product based on insurance and availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments: _____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Psoriatic Arthritis, ICD 10: L40._____ ❑ Crohn's Disease, ICD 10: K50._____
❑ Psoriasis, ICD 10: L40._____ ❑ Ulcerative Colitis, ICD 10: K51._____
❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:
❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Ustekinumab	❑ 260 mg ❑ 390 mg ❑ 520 mg	IV	x 1 dose
	❑ 45 mg ❑ 90 mg	Subcutaneous inj.	❑ 8 weeks after initial IV dose then every 8 weeks ❑ Every 8 weeks

x1 IV infusion needs to be completed prior to SubQ injections.
❑ Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS