



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight (kg): _____

IV Access: _____

Allergies: _____

Stelara 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-9: 696.1

Other: _____

ICD-9: _____

Medication Orders:

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

For 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

Other: _____

Labs:

_____ every _____

_____ every _____

_____ every _____

Prescriber Signature

Date

Please Print Name

Fax-Back Infusion Confirmation:

Administration Date: _____

Time: _____