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-10: L40.0
- ❑ Other: ______________________________ ICD-10: ______________

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: ______________