Ustekinumab IV (Stelara, Otulfi, Yesintek)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ K50.00 Crohn's disease of small intestine without complications

☐ K50.10 Crohn's disease of large intestine without complications

☐ K50.90 Crohn's disease, unspecified without complications

☐ K51.00 Ulcerative (chronic) pancolitis without complications

☐ K51.90 Ulcerative colitis, unspecified without complications

☐ Other:

PRIMARY MEDICATION ORDER

Ustekinumab IV (Stelara) or other Ustekinumab product (as required by patient's health plan)

• Arbor Infusion will only administer the IV induction dose
• Provider's office is required to coordinate maintenance Subq doses
• Administer through an intravenous line containing a sterile, low-protein binding 0.2 micron in-line filter.

☑ Ulcerative Colitis (UC) – or – Crohn's Disease (CD)

☐ **Weight <55kg:** Stelara 260mg IV once

☐ **Weight 55-85kg:** Stelara 390mg IV once

☐ **Weight >85kg:** Stelara 520mg IV once

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Ustekinumab

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772
☐ Arbor Infusion Carmel (317) 981-1772