Nevada Infusion
Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511
Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706
PH: 775-453-0667 | Fax: 775-470-8478

Stelara Order Form

Patient Name: _____ DOB:_____

Phone:_____ Address: _____

City: _____ State:_____ Zip:_____ Email: _____

Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Plaque Psoriasis ICD-10 Code: _____
- ☐ Psoriatic Arthritis ICD-10 Code: _____
- ☐ Crohn's Disease ICD-10 Code: _____
- ☐ Ulcerative Colitis ICD-10 Code: _____
- ☐ Other:_____
  ICD-10: _____

ORDER FOR STELARA (USTEKINUMAB):

Initial Infusion - Adult Dosing:

- ☐ **≤55kg (<121 lbs.) 260mg IV over 1 hour x 1 dose**
- ☐ **>55kg to 85kg (121 lbs. to 187 lbs.) 390mg IV over 1 hour x 1 dose**
- ☐ **>85kg (>187lbs.) 520mg IV over 1 hour x 1 dose**

Maintenance Dosing:

- ☐ **90mg subQ 8 weeks after initial infusion and then every 8 weeks for 1 year**
- ☐ Other Dosing: _____Frequency:_____x 1 year

PRE-MEDICATIONS:

- ☐ Pre-Medications may be PRN (as needed)
- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS Pre/Post Infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____

Physician Signature: _____ Date:_____

Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised: 03/2026

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed Provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Include labs and/or test results to support diagnosis
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, 6-MP)?

☐ Yes OR ☐ No

If yes, which drug(s)? _____

☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Otezla, Stelara, Cimzia)?

☐ Yes OR ☐ No

If yes, which drug(s)? _____

☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %

☐ If psoriasis diagnosis, Psoriasis Area and Severity Index (PASI) score: _____

☐ Include labs and/or test results to support diagnosis

☐ If applicable - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash out period of _____ weeks prior to starting Stelara.

☐ Other medical necessity: _____

Additional REQUIRED Information:

☐ TB screening test completed within 12 months - (please attach results)

☐ Positive OR ☐ Negative

*If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

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