Stelara (ustekinumab)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- ☐ K50.00 Crohn's disease of small intestine without complications (CD)
- ☐ K50.019 Crohn's disease of small intestine with unsp comp (CD)
- ☐ K50.10 Crohn's disease of large intestine without complications (CD)
- ☐ K50.90 Crohn's disease, unspecified, without complications (CD)
- ☑ K51.00 Ulcerative (chronic) pancolitis without complications (UC)
- ☐ K51.90 Ulcerative colitis, unspecified, w/o complications (UC)
- ☐ L40.5 Psoriatic Arthritis (PsA)
- ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Loratadine (Claritin) 10mgPO
- Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐PO ☐IV
- Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
- Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Neg TB Results
☐ Other: _____

Stelara Administration (Select one):

Induction Doses (to be administered in infusion clinic):

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

- ☐ *Weight <55kg:* 260mg IV once
- ☐ *Weight 55kg-85kg:* 390mg IV once
- ☐ *Weight >85kg:* 520mg IV once

Plaque Psoriasis (Ps) – or – Psoriatic Arthritis (PsA)

- ☐ *Weight ≤ 100kg:* 45mg subQ at weeks 0, 4, and every 12 weeks thereafter
- ☐ *Weight > 100kg:* 90mg subQ at weeks 0, 4, and every 12 weeks thereafter

Maintenance Doses:

- ☐ Infusion clinic will coordinate with SP for self-administration or administration in-clinic as payor dictates: **Stelara 90mg subQ every 8 weeks after induction dose.**
- ☐ The provider's office will coordinate the initial maintenance dose from SP.

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454