



Atrium Health
Infusion Center

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Pineville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Southpark Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Huntersville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC Fax: 704-512-5390

Stelara® (ustekinumab) Injection Order (Revised 3/12/2026)

All orders with a √ will be placed.

Patient Demographics

Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
<input type="checkbox"/> NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

<input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified	<input type="checkbox"/> L40.0 Psoriasis vulgaris
<input type="checkbox"/> L40.59 Other psoriatic arthropathy	<input type="checkbox"/> L40.9 Psoriasis, unspecified
<input type="checkbox"/> K50._____	<input type="checkbox"/> K51._____
<input type="checkbox"/> Other:	

Required Documentation: (required prior to scheduling)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (<i>must include labs pertinent to medication ordered</i>)	<input type="checkbox"/> No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	
Diagnostic Studies Pertinent to Medication Ordered	<input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment Parameters:

Hold treatment and notify provider IF:

- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

Required lab Results: Hep B Profile and PPD/Quantiferon Gold PRIOR to first treatment (**Fax Labs with Order**)

Notify Provider IF: Hep B Panel: POSITIVE or not on file; PPD/Quantiferon Gold: POSITIVE or not on file

Nursing Communication:

- Obtain vital signs pre-treatment. Obtain vital signs post-treatment PRN signs of reaction.
- Monitor patient for signs of reaction for 30mins after completion of 1st injection and subsequent injections PRN if previous signs of reaction observed.

Infusion Therapy:

Ustekinumab (Stelara) SC week 0 and week 4

- 45mg (≤ 100kg)
- 90mg (>100kg)

Ustekinumab (Stelara) SC every 12 weeks

- 45mg (≤ 100kg)
- 90mg (>100kg)

Ustekinumab (Stelara) 90 mg SC every 8 weeks

Supportive Care Medications:

- Acetaminophen (Tylenol) 500mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first.
- Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
- Ondansetron (Zofran) tablet 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

- Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity

Prescriber Information:

Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	

Physician Signature: (Order expires 12 months from date of signature) No Stamp Signatures Accepted

Signature:	Date:
------------	-------