BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height _____ Weight _____

Infusion Location: (state and site) _____

Stelara® (ustekinumab) Treatment Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Plaque Psoriasis (ICD-10) _____ Psoriatic Arthritis (ICD-10) _____ Crohn's Disease (ICD-10) _____ Ulcerative Colitis (ICD-10)

_____ Other _____ (ICD-10)

- Nursing Orders:
- -Hold treatment and notify provider for:
  - Signs/symptoms of illness/active infection or cough, night sweats, unexplained weight loss
  - Planned/recent surgical procedures, recent live vaccinations or neurological changes
- Dosing Schedule: Please select all that apply (IV only, IV + Sub-q)

☐ Initial Intravenous Dose (must be IV)

On week 0, give Stelara for Crohn's disease and Ulcerative colitis

☐ 260mg
☐ 390mg
☐ 520mg

Mixed in 250ml 0.9% NS over 1 hour using an in-line, sterile, non-pyrogenic low-protein binding filter (0.2 micron). One time dose only IV

☐ Give _____ mg subcutaneously every _____ weeks

☐ Observation Period:
☐ If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 5/3/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.