McLeod Health

Ustekinumab (Stelara) Treatment Plan for Dermatology/Rheumatology

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one):

☐ L40.50 Arthropathic psoriasis, unspecified ☐ L40.0 Psoriasis vulgaris

☐ L40.52 Psoriatic arthritis mutilans ☐ L40.53 Psoriatic spondylitis

☐ L40.9 Psoriasis, unspecified

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

☐ Induction: Ustekinumab (Stelara) (J3357) SC injection on Weeks 0, 4, and then every 12 weeks thereafter

Dose: ☐ 45 mg

☐ 90 mg (suggested for patients > 100 kg with psoriasis or psoriatic arthritis with co-existent moderate to severe plaque psoriasis)

☐ Maintenance: Ustekinumab (Stelara) (J3357) SC injection every 12 weeks *to be initiated 12 weeks following induction dose*

Dose: ☐ 45 mg

☐ 90 mg (suggested for patients > 100 kg with psoriasis or psoriatic arthritis with co-existent moderate to severe plaque psoriasis)

☐ Other: _____

- Order Duration: One year unless otherwise specified (Other: _____)

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Approved: 10/2024, Last Reviewed: 01/2026

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received ustekinumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.