

Stelara (Ustekinumab)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

TB status & date (list results here & attach clinicals)

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg | 650mg | 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg | 50mg | PO | IV

methylprednisolone (Solu-Medrol) 40mg | 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____

Frequency: _____

THERAPY ADMINISTRATION

- ustekinumab** (Stelara) in 250ml 0.9% sodium chloride, intravenous infusion, use in line filter 0.2 micron
- Dose: 260mg [2 vials] / 390mg [3 vials] / 520mg [4 vials]
 - Frequency: single intravenous infusion (week 0)
 - Route: intravenous
 - Infuse over at least 60 minutes
 - Flush with 0.9% sodium chloride at infusion completion

- ustekinumab** (Stelara) one-time intravenous infusion followed by subcutaneous dose 8 weeks later
- Dose: 260mg [2 vials] / 390mg [3 vials] / 520mg [4 vials]
 - Frequency: single intravenous infusion (week 0)
 - Route: intravenous
 - Infuse over at least 60 minutes
 - Flush with 0.9% sodium chloride at infusion completion
 - SC Dose: 90mg
 - Frequency: subcutaneous dose at week 8 after week 0 intravenous dose and every 8 weeks thereafter
 - Route: subcutaneous

- Subcutaneous ustekinumab** (Stelara)
- Dose: 0.75mg/kg / 45mg / 90mg
 - Frequency: induction: week 0 and 4, then every 12 weeks / maintenance: every 12 weeks / other _____
 - Route: subcutaneous
 - Patient is required to stay for 30-minute observation
 - Refills: Zero / for 12 months / _____
- (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

 Provider Name (Print)

 Provider Signature

 Date