STELARA® (USTEKINUMAB) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

TB Status:

☐ PPD (negative) – date:
☐ Last chest x-ray – date:
☐ QuantiFERON or T Spot Assay result and date: _____
☐ Active TB
☐ Unknown
☐ Past positive TB infection, course taken: _____

Stelara® (Ustekinumab) Prescription

Stelara® (Ustekinumab) refill as directed x 1 year

Initial Dose: ☐ IV: Infuse over at least 1 hour once (check one): ☐ 260mg (up to 55kg) ☐ 390mg (>55kg to 85kg) ☐ 520mg (>85kg)

☐ SUBQ: Nurse to inject _____ mg SUBQ initially and repeat 4 weeks later.

Maintenance Dose: ☐ Nurse to inject _____ mg SUBQ every _____ weeks.

Next Dose Due Date: _____

For IV doses, quantity sufficient of Stelara® 130 mg/26 mL (5 mg/mL) solution in single-dose vials will be dispensed to fulfill dose.
For SUBQ doses, quantity sufficient of Stelara® 45 mg/0.5 mL single-dose vials will be dispensed to fulfill dose – nurse to assess and determine appropriate needle size for administration.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen _____ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine _____ mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via (IV/SQ) access device as indicated above. Nurse will provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

