

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:☐ Active TB☐ Last chest x-ray – date:☐ Unknown☐ QuantiFERON or T Spot Assay result and date: _____☐ 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:

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