

**STELARA® (USTEKINUMAB) PRESCRIBER ORDER FORM**

<b>Patient Name:</b>		<b>Date of Birth:</b>	<b>Gender:</b>	
<b>Address:</b>				
<b>Phone:</b>		<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>
				<input type="checkbox"/> lbs <input type="checkbox"/> kg

**Clinical Information**

<b>Primary Diagnosis Description:</b>		<b>ICD-10 Code:</b>
<b>TB Status:</b>	<input type="checkbox"/> PPD (negative) – date: _____	<input type="checkbox"/> Active TB
	<input type="checkbox"/> Last chest x-ray – date: _____	<input type="checkbox"/> Unknown
	<input type="checkbox"/> QuantiFERON or T Spot Assay result and date: _____	<input type="checkbox"/> 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. **Date of last Dose:** \_\_\_\_\_

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 1<sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> 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.  
 If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

*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**

<b>Prescriber Name:</b>		<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>		<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>	

**Fax completed form, insurance information, and clinical documentation to: 713-983-4647**

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