HEALTH CARE MEDICAL
Infusion Specialties
An Access Infusion Care Company

STELARA (USTEKINUMAB) ORDERS

PATIENT INFORMATION		PRESCRIBER INFORMATION
Patient Name: _____		Prescriber Name: _____
Address: _____		NPI: _____
City, State, Zip: _____		Address: _____
Cell: _____	Email _____	City, State, Zip: _____
Height _____ Weight _____kg Last 4 of SSN: _____ DOB: _____		Phone: _____Fax: _____
Allergies: _____ _____		Contact Person: _____

REFERRAL STATUS	
☐ New Referral	First dose? ☐ Yes ☐ No - Date of last infusion: _____
☐ Dose or Frequency Change	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other
☐ Continuation Order	

DIAGNOSIS	
☐ Crohn's Disease ICD 10 Code_____	☐ Plaque Psoriasis ICD 10 Code _____
☐ Psoriatic Arthritis ICD 10 Code_____	☐ Ulcerative Colitis ICD 10 Code_____
☐ ICD-10 CODE: _____	

REQUIRED DOCUMENTATION	
• This signed order form by the provider	• Prior Therapies: _____
• Patient demographics and insurance information	• TB Screening ☐ Positive ☐ Negative Date: _____
• H&P, labs, tests, and progress notes supporting diagnosis	• Hepatitis Screening ☐ Positive ☐ Negative Date:_____

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
Ustekinumab Specific Brand (optional): _____	☐ 130 mg/ 26 ml	Loading dose for Crohn's Disease and Ulcerative Colitis Dilute in 0.9% NS 250 ml (100 ml for pediatric patients 10-25kg) and infuse IV over 1 hour ☐ 260 mg (<55 kg) ☐ 390 mg (55-85 kg) ☐ 520 mg (>85 kg)	Qty: sufficient for weight-based doses
	☐ 45 mg/ 0.5 ml ☐ 90 mg/ ml	☐ Inject subcutaneously at week 0,4, then every 12 weeks ☐ Inject subcutaneously at week 8 after IV loading dose, then every 8 weeks ☐ Inject subcutaneously every _____ weeks	Qty: sufficient for dose per month Refill: _____

If no product is specified, an insurance-preferred biosimilar may be used.

PREMEDICATIONS (administer 30 minutes prior to infusion)

☐ Acetaminophen: ☐ 650 mg PO ☐ 1000 mg PO

☐ Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO

☐ Lab Work every _____ ☐ CMP ☐ CBC w dif ☐ CRP ☐ Sed Rate ☐ _____

PIV: Flush with 3–10 mL of 0.9% sodium chloride before and after the infusion PICC/Midline: Flush 10 mL 0.9% NS before/after, then 3 mL Heparin 10 units/mL final flush Port: Flush 10 mL 0.9% NS before/after, then 5 mL Heparin 100 units/mL final flush	RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline Post-Infusion: Use 50 ml 0.9% NS bag to flush residual priming volume

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Print, complete, and fax completed form to: (769) 233-8051

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EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Pediatrics and Adults under (<40 kg): Diphenhydramine 25 mg PO or IV slow push (2–5 min); Acetaminophen 325 mg PO; Methylprednisolone 40 mg IV slow push (≥5 min); Epinephrine 0.15 mg (<30 kg) or 0.3 mg (>30 kg) IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____ X: _____

Product Substitution Permitted: _____ Date: _____ Dispense as Written: _____ Date: _____

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