STELARA® (USTEKINUMAB) PRESCRIBER ORDER FORM

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

	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: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

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) SQ 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.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

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: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 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:**	

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