

Stelara (ustekinumab) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card • Patient demographics • History & physical • Labs • Tuberculosis (TB) screening results

2. Patient Information

☐ Male ☐ Female Height: _____ ☐ in/☐ cm Weight: _____ ☐ lbs/☐ kg ☐ NKDA Allergies
Line type (if applicable): ☐ PIV ☐ PICC ☐ Port ☐ Other:

3. Diagnosis and Clinical Information ICD-10 (required):

☐ Crohn's disease ☐ Ulcerative colitis ☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Other:

4. Prescription Information: Stelara (IV: 130 mg/26 mL vials; SQ: 45 mg/0.5 mL vials)

Indication	Dosing
Crohn's Disease, Ulcerative Colitis	<input type="checkbox"/> Initial Dose: Infuse IV one time: <input type="checkbox"/> 260 mg (≤ 55 kg) <input type="checkbox"/> 390 mg (> 55 kg to 85kg) <input type="checkbox"/> 520 mg (> 85 kg) Prepare infusion per manufacturer guidelines. Infuse over at least 1 hour, as tolerated, use an in-line 0.2 micron filter <input type="checkbox"/> Maintenance Dose: Inject 90 mg SUBQ every 8 weeks
Psoriatic Arthritis, Plaque Psoriasis	<input type="checkbox"/> Initial Dose: Inject _____ mg SUBQ initially and then again 4 weeks later <input type="checkbox"/> Maintenance Dose: Inject _____ mg SUBQ every 12 weeks
Other	<input type="checkbox"/> Initial Dose: Inject _____ mg SUBQ initially and then again 4 weeks later <input type="checkbox"/> Maintenance Dose: Inject _____ mg SUBQ every _____ weeks
Quantity / Refills	Dispense 1 month supply / QS on all medications. Dispense medical supplies for administration Refill x 12 months OR <input type="checkbox"/> Other:

5. Additional Orders

For SQ injections: Provide skilled nursing to teach injection technique if needed

For IV infusion (if ordered): RN to start peripheral IV or use existing CVC. Administer catheter flushing per Coastal Infusion Services Policy & Procedure.

Premedication: Give 30 min prior to IV infusion (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing > 40 kg):

- ☐ Diphenhydramine 25-50mg PO. Patient may decline.
☐ Acetaminophen 325-650mg PO. Patient may decline.
☐ Methylprednisolone 40mg (OR _____ mg) slow IV push
 (or an equivalent corticosteroid, substitution if needed)

Pediatrics (weighing < 40 kg): (*may adjust with weight changes*)

- ☐ Diphenhydramine 1mg/kg PO
☐ Acetaminophen 15mg/kg PO
☐ Methylprednisolone 1 mg/kg (OR _____ mg) slow IV push
 (or an equivalent corticosteroid, substitution if needed)

☐ Other orders:

- RN to monitor patient post-infusion per Coastal Infusion Services Policy & Procedure and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders: For first doses, standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional/other orders:

Note: If epinephrine auto-injector is required, prescriber to send prescription to retail pharmacy of patient's choice

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 License #: _____ DEA #: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

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