COASTAL INFUSION SERVICES

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Madisonville, LA 70447
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Toll-Free: 833-235-1686

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	☐ **Initial Dose:** Infuse IV one time: ☐260 mg (≤55kg) ☐390 mg (>55kg to 85kg) ☐520 mg (>85kg) Prepare infusion per manufacturer guidelines. Infuse over at least 1 hour, as tolerated, use an in-line 0.2 micron filter ☐ **Maintenance Dose**: Inject 90 mg SUBQ every 8 weeks
Psoriatic Arthritis, Plaque Psoriasis	☐ **Initial Dose**: Inject _____ mg SUBQ initially and then again 4 weeks later ☐ **Maintenance Dose**: Inject _____ mg SUBQ every 12 weeks
Other	☐ **Initial Dose**: Inject _____ mg SUBQ initially and then again 4 weeks later ☐ **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 ☐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 toIV infusion (*Note: if nothing is checked, no premedications will be given*)

Adults (or patients weighing >40kg):	**Pediatrics (weighing <40 kg):** *(may adjust with weight changes)*
☐Diphenhydramine 25-50mg PO. Patient may decline.	☐Diphenhydramine 1mg/kg PO
☐Acetaminophen 325-650mg PO. Patient may decline.	☐Acetaminophen 15mg/kg PO
☐Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed)	☐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 b e 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.