Stelara (Ustekinumab)

Infusion Order Form – Page 1 of 2

Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list

Supporting clinical notes (H&P) to support primary diagnosis:

- TB results for both baseline and ongoing monitoring
- Lab results for ongoing mandatory monitoring
- Patient has active moderate to severe Crohn's disease or Ulcerative Colitis
  - Who has failed or was intolerant to treatment with immunomodulators or corticosteroids but never failed treatment with a tumor necrosis factor blocker
  - or failed or were intolerant treatment with one or more TNF blockers
- Patient has active psoriatic arthritis
- Patient has moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

PRE-MEDICATION

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

THERAPY

☐ **Ustekinumab** (Stelara) in 250ml 0.9% sodium chloride,intravenous infusion, use in line filter 0.2 micron

- Dose: ☐ 260mg (2 vials) ☐ 390mg (3 vials) ☐ 520mg (4 vials)
- Frequency: single intravenous infusion (week 0)
- Infuse over at least 60 minutes
- Flush with 0.9% sodium chloride at infusion completion

☐ **Ustekinumab** (Stelara) one-time intravenous infusion followed by subcutaneous dose 8 weeks later

Initial Intravenous Dose: ☐ 260mg (2 vials) ☐ 390mg (3 vials) ☐ 520mg (4 vials)

- Frequency: single intravenous infusion (week 0)
- Route: Intravenous
- Infuse over at least 60 minutes
- Flush with 0.9% sodium chloride at infusion completion

Subsequent Subcutaneous Dose: ☑ 90mg

- Frequency: subcutaneous dose at week 8 after week 0 intravenous dose and every 8 weeks thereafter

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Harbor Health

Stelara (Ustekinumab)

Date: Patient Name: DOB:

Orders, cont.

THERAPY

☐ **Subcutaneous ustekinumab** (Stelara)

- Dose: ☐ 0.75mg/kg ☐ 45mg ☐ 90mg
- Frequency: ☐ induction: week 0 and 4, then every 12 weeks
- Maintenance: ☐ every 12 weeks / ☐ other:_____

☐ Patient is required to stay for 30-minute observation

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

(if not indicated order will expire one year from date signed)

Special Instructions

NOTES:

Provider Name (Print): Provider Signature: Date:

Harbor Health