ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Ustekinumab (Stelara)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____
Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: **ICD -10 Code:**

❑ Plaque psoriasis ❑ _____
❑ Psoriasis arthritis ❑ _____
❑ Crohn's disease ❑ _____
❑ Ulcerative colitis ❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **Reason patient not able to self-administer medication:** _____

Baseline labs required:

- Latent TB testing Date: _____/_____/_____ Results: _____
- HBV screening Date: _____/_____/_____ Results: _____
- HCV screening Date: _____/_____/_____ Results: _____
- HIV screening Date: _____/_____/_____ Results: _____
- CBC, CMP

Maintenance labs required:

- Annual Latent TB testing
- CBC, CMP every 6 months

Contact provider if patient develops serious infection; close monitoring by provider is recommended.
Follow-up appointment with referring provider scheduled for (date):_____

Patient weight = _____ lb/kg (required)

Treatment Regimen for Ustekinumaab (Stelara) dose:

Plaque psoriasis: ❑ 45 mg SubQ (Wt <100 kg)
❑ 90 mg SubQ (Wt ≥100 kg)

Psoriasis arthritis: ❑ 45 mg SubQ
❑ 90 mg SubQ (for pts w/ co-existent moderate to severe plaque psoriasis)
Administer both at week 0 and 4 weeks later, followed by administration every 12 weeks

Crohn's/Ulcerative Colitis: ❑ 260 mg IV over 1 hr x 1 dose (</=55 kg)
❑ 390 mg IV over 1 hr x 1 dose (>55-85 kg)
❑ 520 mg IV over 1 hr x 1 dose (>85 kg)
Followed by 90 mg SUBQ 8 weeks after initial IV dose then every 8 weeks

☑ **Vital Signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
USTEKINUMAB (Stelara)

MultiCare

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