

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- | | |
|---|---|
| <input type="checkbox"/> Allenmore Infusion Center | <input type="checkbox"/> DHEC Infusion Center |
| <input type="checkbox"/> Auburn Infusion Center | <input type="checkbox"/> North Spokane Infusion Center |
| <input type="checkbox"/> Gig Harbor Infusion Services | <input type="checkbox"/> North Star Lodge Infusion Center |
| <input type="checkbox"/> Puyallup Infusion Center | |

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:

- Plaque psoriasis
- Psoriasis arthritis
- Crohn's disease
- Ulcerative colitis

ICD -10 Code:

- _____
- _____
- _____
- _____

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 Ustekinumab (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 further 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)

