Ustekinumab (Stelara)

IVX HEALTH

Provider Order Form *rev. 08/21/2023*

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:

NURSING

☑ TB status & date (list results here & attach clinicals)

_____

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation **NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

PRE-MEDICATION ORDERS

☐ 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: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☐ **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)
- Route: intravenous
- 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
- 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
- SC Dose: ☑ 90mg
- Frequency: subcutaneous dose at week 8 after week 0 intravenous dose and every 8 weeks thereafter
- Route: subcutaneous

☐ **Subcutaneous ustekinumab** (Stelara)
- Dose: ☐ 0.75mg/kg / ☐ 45mg / ☐ 90mg
- Frequency: ☐ induction: week 0 and 4, then every 12 weeks / ☐ maintenance: every 12 weeks / ☐ other: _____
- Route: subcutaneous

☐ 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)

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

☐ AUSTIN: 512-772-2824	☐ CONNECTICUT: 860-955-1532	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ RALEIGH: 919-287-2551
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ NORTHWEST AR: 888-615-1445	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ EAST TN: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ LITTLE ROCK: 501-451-5644	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
☐ COLUMBUS: 844-627-2675	☐ HARRISBURG: 844-859-4235	☐ MIAMI: 786-744-5687	☐ PHILADELPHIA: 844-820-9641	☐ TAMPA: 844-946-0849
	☐ HOUSTON: 832-631-9595	☐ MIDDLE TN: 888-615-1445	☐ PIEDMONT TRIAD: 336-790-2200	☐ WEST TN: 888-615-1445