

# Ustekinumab (Stelara)



Provider Order Form rev. 10/4/2021

## PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
<b>Patient Status:</b> <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

## 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 and date (results) \_\_\_\_\_
  - 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](http://www.ivxhealth.com/forms) (version 09.07.2021)

## 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 period
- Patient is NOT required to stay for observation time
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Email [ivxintake@ivxhealth.com](mailto:ivxintake@ivxhealth.com) or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275   | <input type="checkbox"/> COLUMBUS: 844-627-2675     | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445   |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> TAMPA: 844-946-0849        | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
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