Ustekinumab (Stelara)

Provider Order Form rev. 3/25/2022

PATIENT INFORMATION

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ 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 (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**

FAX NUMBERS

	☐ **CHICAGO: 312-253-7244**	☐ **INDIANAPOLIS: 844-983-2028**	☐ **PHILADELPHIA: 844-820-9641**	☐ **WEST TN/AR: 888-615-1445**
	☐ **COLUMBUS: 844-627-2675**	☐ **JACKSONVILLE: 904-212-2338**	☐ **RALEIGH: 919-287-2551**	☐ **MIDDLE TN: 888-615-1445**
☐ **BAY AREA: 844-889-0275**	☐ **DAYTONA: 386-259-6096**	☐ **KANSAS CITY: 844-900-1292**	☐ **SARASOTA: 941-870-6550**	☐ **EAST TN: 615-425-7427**
☐ **CHARLOTTE: 336-663-0143**	☐ **HARRISBURG: 844-859-4235**	☐ **ORLANDO: 844-946-0867**	☐ **SOUTHWEST FL: 813-283-9144**	
☐ **CINCINNATI: 844-946-0868**	☐ **HARTFORD: 860-955-1532**	☐ **PALM BEACH: 561-768-9044**	☐ **TAMPA: 844-946-0849**	