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:

❑ Psoriasis

❑ Other__________________________

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:

Ustekinumab (Stelara) Dose: ❑ 45 mg SubQ (Wt <100 kg) OR ❑ 90 mg SubQ (Wt ≥100 kg)

Crohn disease/ Ulcerative Colitis: ❑ </=55 kg = 260 mg IV over 1 hour

❑ >55 kg - 85 kg = 390 mg IV over 1 hour

❑ >85 kg = 520 mg IV over 1 hour

❑ Administer at week 0 (initial) and 4 weeks later, followed by administration every 12 weeks x 6 months

OR

❑ Continue maintenance dose every 12 weeks (if patient has completed initiation) x 6 months

☑ **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)