ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	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.

USTEKINUMAB (Stelara) INTRAVENOUS

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE:

- ❑ Crohn's disease (ICD-10: _____) ❑ Ulcerative colitis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:

- ✓ CBC & CMP within 30 days prior to first infusion
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)

ROUTINE LABS: ❑ CMP | ❑ CBC | ❑ Other: _____
ROUTINE LAB FREQUENCY: ❑ Annually | ❑ Other: _____

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

❑ **Ustekinumab (Stelara) IV Induction (Crohn's disease & ulcerative colitis)**
Subcutaneous maintenance therapy to start 8 weeks after induction dose – Please arrange with the patient's preferred outpatient or specialty pharmacy.

- ❑ Weight 55 kg or less: 260 mg IV over at least 1 hour x 1 dose
- ❑ Weight > 55 kg to 85 kg: 390 mg IV over at least 1 hour x 1 dose
- ❑ Weight > 85 kg: 520 mg IV over at least 1 hour x 1 dose
- ❑ Other Induction: _____ mg IV over at least 1 hour x 1 dose **attach rationale/clinical documentation to support non-FDA approved dosage*

❑ **Ustekinumab (Stelara) IV Maintenance** **additional rationale/clinical documentation to support non-FDA approved regimen is required.*

- o Infuse _____ mg IV over 1 hour every _____ weeks

MONITORING: Vitals at baseline and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

***DISCHARGE*:** 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

USTEKINUMAB (Stelara) INTRAVENOUS

MultiCare
Yakima Memorial Hospital