Fax: 832-895-4040
Phone: 832-895-5000
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adaptIV infusion

Stelara (Ustekinumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

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

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

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

_____

☐ Provide nursing care per adaptIV infusion Nursing Procedures, including reaction management and post-procedure observation

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: _____

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)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____

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

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK