

Ustekinumab (Stelara)



Provider Order Form

PATIENT INFORMATION

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

PROVIDER INFORMATION

Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post-procedure observation
- TB status and date (results) _____

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
- 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
 - IV 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 completion of infusion
- ustekinumab** (Stelara) one-time intravenous infusion followed by subcutaneous dose 8 weeks later
 - IV 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 completion of infusion
 - 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 post infusion/injection
- 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)

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT PROTOCOL

- Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting
- If reaction occurs:
 - Stop infusion.
 - Maintain/establish vascular access.
 - Notify referring provider as clinically appropriate and follow clinical escalation protocol.
 - IVX Health clinicians have the following PRN medications available for the following reactions.
 - Headache, pain, fever > 100.4F, chills or rigors- Acetaminophen 650mg PO or Ibuprofen 400mg PO.
 - Mild Hives, itching, redness, or rash- Loratadine 10mg PO or Diphenhydramine 50mg PO.
 - Severe hives, itching, redness, or rash- Diphenhydramine 25-50mg SIVP.
 - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
 - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
 - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 250ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
 - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
 - Solumedrol 125mg IV- Refractory to other treatments given.
 - Other _____
 - When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.
- Severe allergic/anaphylactic reaction:**
 - If symptoms are rapidly progressing or continuing after administration of PRN medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
 - Call 911.
 - Initiate basic life support as needed.
 - Bring the **AED** to the patient (Attach pads if indicated).
 - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
 - Place patient in recumbent position, elevate lower extremities.
 - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
 - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
 - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
 - Administer **methylprednisolone** 125mg IVP, if not previously given.
 - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
 - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

Patient Name

Patient Date of Birth

Provider Name (Print)

Provider Signature

Date

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

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