ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Ustekinumab (Stelara)

Provider Order Form

IVX HEALTH formerly Infusion Express

Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
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-infusion observation
- ☑ TB status and date (Please provide results) _____

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- ☐ 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:

INFUSION THERAPY

- ☐ 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 the 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 the 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 in NOT required to stay for observation
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____(if not indicated order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Special instructions/notes:

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

ADULT REACTION MANAGEMENT

☑ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation

☑ If reaction occurs:

- Stop infusion
- Maintain/establish vascular access
- Notify referring provider
- Consider giving the following PRN
  1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
  2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
  3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
  4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
  5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
  6. Other _____
- When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's 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.)
  1. Call 911
  2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
  3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
  4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
  5. Have Automated External Defibrillator available
  6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
  7. Discontinue treatment

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ☐ San Mateo ☐ Fremont ☐ San Ramon ☐ TBD

ILLINOIS fax: (312) 253-7244 | ☐ Glenview ☐ Schaumburg ☐ TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ☐ Overland Park, KS ☐ Lee's Summit, MO ☐ Briarcliff, MO ☐ TBD

OHIO fax: (844) 627-2675 | ☐ Dublin ☐ Pickerington ☐ TBD

PENNSYLVANIA fax: (844) 820-9641 | ☐ Malvern ☐ Bensalem ☐ Montgomeryville ☐ East Shore ☐ West Shore ☐ TBD

TENNESSEE fax: (844) 627-2518 | ☐ Brentwood ☐ Hendersonville ☐ TBD

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