Fax Form to: 330-294-2082

INDY INFUSION

Ustekinumab (Stelara)

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

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

☑ Provide nursing care , 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: _____

SPECIAL INSTRUCTIONS

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)

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

Please include the following information when submitting a referral for Stelara IV:

Result of Tuberculosis (TB) skin/lab testing
Patients current weight and height
Patient has active moderate to severe Crohn's disease (CD)
Who has failed or was intolerant to treatment with immunomodulators or corticosteroids but never failed treatment with a tumor necrosis factor blocker Or failed or were intolerant to treatment with one or more TNF blockers
Patient has active psoriatic arthritis
Patient has moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
Please include the following information when submitting a referral for Stelara SQ:
Results of a recent tuberculosis (TB) skin/lab testing
Patient's current weight and height
For Crohn's patients, include date of induction dose given
Clinicals to support one or more of the following:
Patient has moderately to severely active Crohn's disease (CD) and evidence to support one or more of the following:
Failed or was intolerant to treatment with immunomodulators or corticosteroids but never failed treatment with a tumor necrosis factor blocker OR Failed or was intolerant to treatment with one or more TNF blockers
Patient has active psoriatic arthritis
Patient has moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy