

STELARA (USTEKINUMAB) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

☐ K50.90 – Crohn's disease, unspecified ☐ L40.0 – Plaque psoriasis

☐ K50.80 – Crohn's disease of small and large intestine ☐ L40.52 – Psoriatic arthritis

☐ K51.90 – Ulcerative colitis, unspecified

☐ Other: ☐ ICD-10 CODE:

INFUSION ORDER

Induction Phase:

☐ 55–85 kg: 390 mg IV (3 vials) ☐ Infuse over ≥60 minutes using 0.2-micron in-line filter

☐ >85 kg: 520 mg IV (4 vials) ☐ Observation: ☐ 30 minutes ☐ 60 minutes post-infusion

☐ Dilute in 250 mL 0.9% sodium chloride ☐ Maintenance: 90 mg subcutaneous injection every 8 weeks (to begin 8 weeks after IV dose)

☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other:

LINE USE & ACCESS

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)

☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

☐ Acetaminophen: ☐ 650 mg ☐ PO ☐ PO ☐ IV

☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone: ☐ 125 mg ☐ IV

☐ Cetirizine: ☐ 10 mg ☐ PO

☐ Famotidine: ☐ 20 mg ☐ IV

☐ Other: Dose: Route:

LABORATORY MONITORING

☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ Hepatitis B Panel (HBsAg and anti-HBc)

☐ TB Screening (Quantiferon Gold or equivalent within 12 months) ☐ Other:

Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other:

☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

☐ Documentation of prior therapies or intolerance ☐ TB and Hepatitis B screening results

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: