Stelara® (Ustekinumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________

Phone: ______________ Height: ________ ☐ inches ☐ cm Weight: ________ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: ______________________ ICD-10 Code(s): ______________

TB Status
- ☐ PPD (negative) – date: ______________ ☐ Active TB ☐ Unknown
- ☐ Last chest x-ray – date: ______________ ☐ Other ______________
- ☐ Past positive TB infection, course taken: ______________

Stelara® (Ustekinumab) Prescription

Stelara® (Ustekinumab) refill as directed x 1 year

Initial Dose: ☐ IV: Infuse over at least 1 hour once (check one): ☐ 260mg (up to 55kg) ☐ 390mg (>55kg to 85kg) ☐ 520mg (>85kg)
☐ SUBQ: Nurse to inject ________ mg SUBQ initially and repeat 4 weeks later.

Maintenance Dose: ☐ Nurse to inject ________ mg SUBQ every ________ weeks.

Next Dose Due Date: ______________

For IV doses, quantity sufficient of Stelara® 130 mg/26 mL (5 mg/mL) solution in single-dose vials will be dispensed to fulfill dose.

For SUBQ doses, quantity sufficient of Stelara® 45 mg/0.5 mL single-dose vials will be dispensed to fulfill dose – nurse to assess and determine appropriate needle size for administration.

Ancillary Orders

Anaphylaxis Orders
- ☐ Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders
- ☐ Acetaminophen ________ mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- ☐ Diphenhydramine ________mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Other: ______________

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:
- ☐ Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- ☐ Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders
- ☐ No labs ordered at this time.
- ☐ Other: ______________

Skilled nurse to assess and administer via (IV/SQ) access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature ______________ Date ________ Time ________

Prescriber Name ______________ Phone ________ Fax ________

Address ______________ NPI ________

City, State, Zip ______________ Office Contact ________

Froedtert Home and Specialty Infusion
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