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Ustekinumab (Stelara) Treatment Plan for Gastroenterology

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

□ K50.0___ Crohn's Disease (small intestine)

□ K50.1___ Crohn's Disease (large intestine)

□ K50.8___ Crohn's Disease (small and large intestine)

□ K50.9___ Crohn's Disease, Unspecified

□ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

□ None

□ Acetaminophen 650 mg PO

□ Diphenhydramine: Dose: □ 25 mg □ 50 mg Route: □ PO or □ IVP

□ Methylprednisolone: Dose: □ 40 mg or □ 125 Route: IVP

□ Famotidine: Dose: 20 mg Route: □ PO or □ IVPB

□ Other (include drug, dose, and route): _____

Drug Orders:

□ Induction: Ustekinumab (Stelara) (J3358) per 250 mL Sodium Chloride 0.9% IV to infuse over 1 hour for 1 dose

Dose: □ Weight < 55 kg: 260 mg

□ Weight= 55-85 kg: 390 mg

□ Weight > 85 kg: 520 mg

● Subcutaneous maintenance dosing to be initiated 8 weeks following loading dose and coordinated by physician office

Lab Orders:

□ _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received ustekinumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)