Place Sticker Here

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)

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

☐ K50.1___ Crohn's Disease (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.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)