# Stelara IV Order Form
## (ustekinumab)

**FAX TO: 972.499.9210**

## PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

**Patient Preferred Location:** _____

## DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

**ICD 10 Code (PROVIDE COMPLETE CODE)**

- ☐ K50.0_____ Crohn's Disease, Small Intestine
- ☐ K50.1_____ Crohn's Disease, Large Intestine
- ☐ K50.8_____ Crohn's Disease, Small & Large Intestine
- ☐ K50.9_____ Crohn's Disease, Unspecified
- ☐ K51.8_____ Other Ulcerative Colitis, Chronic
- ☐ K51.5_____ Left Sided - Ulcerative Colitis, Chronic
- ☐ K51.0_____ Universal Ulcerative Pancolitis, Chronic
- ☐ K51.9_____ Ulcerative Colitis, Unspecified

Other: _____

***REQUIRED:*** **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
***LAB RESULTS:*** **Include Negative TB within 12 months.**

## PRESCRIPTION

**Pre-Medications**

- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP

Other: _____

**Lab Orders+**

*Required:* Negative TB, annually

**+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.**

### Stelara (ustekinumab)

☐ **IV Loading Dose**

Dilute in total volume of 250 mL of 0.9% Sodium Chloride over at least one hour via pump using a 0.2-mircon filter.

**IV:** (wt < 56 kg): Infuse 260 mg (2 vials) as a single dose
**IV:** (wt 56 kg – 85 kg): Infuse 390 mg (3 vials) as a single dose
**IV:** (wt > 85 kg): Infuse 520 mg (4 vials) as a single dose

**Patient Weight:** _____ lbs **or** _____ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Post Treatment Observations:** The patient is observed for 60 minutes following loading dose.

**Comments:** _____

_____

_____

_____

_____

## PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____