Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Stelara® (ustekinumab) Standard Plan of Treatment for Gastroenterology

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	K50.0____ - Crohn's disease (small intestine)	☐	K51.2____ - Ulcerative (chronic) proctitis
☐	K50.1____ - Crohn's disease (large intestine)	☐	K51.3____ - Ulcerative (chronic) rectosigmoiditis
☐	K50.8____ - Crohn's disease (small & large intestine)	☐	K51.5____ - Left sided colitis
☐	K50.9____ - Crohn's disease, unspecified	☐	K51.8____ - Other ulcerative colitis
☐	K51.0 ____ - Ulcerative (chronic) pancolitis	☐	K51.9____ - Ulcerative colitis, unspecified
☐	_____ - Other:		

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6			

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ustekinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

FDA labeling does not suggest premedication.

IV	Diphenhydramine	☐	25mg	☐	50mg					
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:			
	Famotidine	☐	20mg	☐	40 mg					
	Other:	☐								
PO	Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg	
	Famotidine	☐	20mg	☐	40mg					
	Diphenhydramine	☐	25mg	☐	50mg					
	Fexofenadine	☐	60mg	☐	180mg					
	Cetirizine	☐	10mg							
	Loratadine	☐	10mg							
	Other:	☐								

MEDICATION/DOSE/FREQUENCY:

☐ Induction: Stelara® (ustekinumab) single IV dose per 250ml NS IV to infuse over at least 1 hour.

Body weight of patient	Dose
less than 55 kg	260 mg
55-85 kg	390 mg
greater than 85kg	520 mg

☐ Maintenance: Stelara® (ustekinumab) 90 mg subcutaneously 8 weeks after initial IV and every 8 weeks thereafter

Administer as subcutaneous injection to upper arm, thigh, or abdomen.

SPECIAL/LAB ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	