AMBULATORY INFUSION AND IN HOME ORDERS/SPECIALTY ORDERS					
Referral Status:				MRN:	
	New referral		Order change		Order Renewal
Patient preferred clinic:					

Stelara® (ustekinumab) Standard Plan of Treatment for Gastroenterology

Rev 3.14.25

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
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	**REQUIRED:** TB screening for new start patients

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

AMBULATORY INFUSION 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

SPECIAL/LAB ORDERS:

☐ ____

____

IN HOME/SPECIALTY PHARMACY ORDERS:

☐ 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.

Some commercial insurance plans require maintenance doses to be provided by the plan's specialty pharmacy. Providers will be notified if Palmetto Infusion cannot dispense the maintenance doses due to plan restrictions or patient preference.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ✔ Start PIV/Access CVC
- ✔ Flush device per facility standard flushing procedure
- ✔ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated
- ✔ In Home Supply orders: All supplies for drug administration and ADR kit to be provided for in home use.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders which can be found on the website. Home Standing orders including Anaphylaxis Kit dispense as written and administer for mild and severe reactions are provided.

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	

IN-HOME INFUSION PHYSICIAN STANDING ORDERS

(CHECK ALL APPLICABLE ORDERS)

Prescriber Office:	**Phone:**	
Patient Name:		**DOB:**
Address:		
City, State:	**Phone:**	**Zip:**

PRESCRIPTION

By signing below, I authorize the administration of flush medications and their associated instructions to our patients. This authorization applies as relevant to the type of access device being utilized. The validity of this order extends for one year from the date of signing.

SKILLED NURSING

A skilled nurse is authorized to assess, administer, and/or provide self-administration education as appropriate. The nurse will offer ongoing support as required. Additionally, all vascular access and ancillary orders mentioned within may be refilled as directed for a duration of one year unless discontinued prior.

VASCULAR ACCESS & ANCILLARY ORDERS

☐ Peripheral:

- ☐ Insertion of 22 or 24 gauge peripheral IV as required for ordered infusion therapy.
- ☐ 0.9% sodium chloride 5 ml pre- and post-infusion.
- ☐ 0.9% sodium chloride 10 mL pre- and post-infusion.
- ☐ Other: ____________________

☐ Peripheral-Midline, PICC and Central Tunneled and Non-Tunneled:

- ☐ Access peripheral-midline, PICC, or central tunneled catheter as required.
- ☐ 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
- ☐ 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
- ☐ Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure

For maintenance flushing/locking:

- ☐ 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
- ☐ Other:____

☐ Implanted Port:

- ☐ Access the implanted port as required.
- ☐ 0.9% sodium chloride 5ml pre- and post-infusion. (5 mL pre-lab draw).
- ☐ 0.9% sodium chloride 10mL pre- and post-infusion. (10 mL pre-lab draw).
- ☐ Heparin (10 unit/mL) 5 mL post-use for flush/locking procedure

For maintenance flushing/locking:

- ☐ 10 mL of 0.9% sodium chloride followed by 5 ml Heparin (100 unit/mL)
- ☐ Other:____

CATHETER OCCLUSION ORDERS

Cathflo Activase- Instill into the occluded catheter. Let dwell for 30 minutes before attempting to aspirate. Dwell time not to exceed 120 minutes.

☐ 1 mg (midlines or patients <30 kg) ☐ 2 mg ☐ **May repeat x 1 dose.**

ANAPHYLAXIS ORDERS

MILD REACTION – Pruritis or rash, dizziness without blood pressure change, arthralgia, headache, nausea

1. Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove the existing drug in the line and discard. Flush line with 10 ml of 0.9% sodium chloride.
2. **Diphenhydramine IV**:
   Dose:
   - ☐ 10 to 30 kg(22-66lbs) or (2-12 years old), 0.5ml (25mg) IV
   - ☐ >30 kg (>66lbs) or over the age of 12 years old, 0.5 ml (25mg) IV
   - ☐ >30 kg (>66lbs) or over the age of 12 years old, 1ml (50mg) IV
3. May repeat x **1 Dose**. (Maximum Adult Daily Dose 300mg/day)
   Monitor vital signs at 15-minute intervals. If patient is back to baseline after 30 minutes, then restart the infusion. If patient is not back at baseline and symptoms persist, continue to monitor, and reassess for 15 additional minutes and to include vitals with each 15-minute interval. When patient is back to baseline restart infusion as tolerated. If mild symptoms persist, call primary ordering physician for guidance to continue or discontinue therapy.

SEVERE REACTION/ANAPHYLAXIS- Urticaria, hypotension, chest pain, shortness of breath, stridor, wheezing, vomiting, severe abdominal or back pain.

1. Stop Infusion and connect 5-10 ml syringe and draw back to a blood return to remove existing drug in the line and discard. Flush line with 10ml of 0.9% sodium chloride. Call EMS 911.
2. **Epinephrine IM Injection: (**Do Not Delay Epinephrine in favor of other drugs/adjunctive therapies.)
   - ☐ Epinephrine IM Injection: **0.15ml/ 0.15mg, 5 to 30 kg (Children, 33 to 66 lbs.)** (Preferably thigh)
   - ☐ Epinephrine IM Injection: **0.3 ml/0.3mg, >30 kg (patients weighing > 66 pounds)**
   - ☐ If there is no response or an inadequate response, a second Epinephrine dose may be administered at 5 to 15 minutes after initial injection.

   Intramuscular injection is given into the mid-outer thigh.

Prescriber Signature:		**Date:**
Authorizing Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State, Zip:	**Office Contact:**	

Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com