

**AMBULATORY INFUSION AND IN HOME ORDERS/SPECIALTY ORDERS**

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

**Stelara® (ustekinumab) Standard Plan of Treatment for Gastroenterology**

Rev 4.28.25

**PATIENT DEMOGRAPHICS:**

Patient Name: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Height in inches: \_\_\_\_\_ Weight: \_\_\_\_\_ LB or \_\_\_\_\_ KG Gender: \_\_\_\_\_ Allergies: \_\_\_\_\_ See list \_\_\_\_\_ NKDA \_\_\_\_\_

**DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?**

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

**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.

<b>IV</b>	Diphenhydramine	25mg	50mg		<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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](http://www.palmettoinfusion.com)