Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Ustekinumab (Stelara) Orders

Name: ______________________________________ DOB: _____________________________

Diagnosis/Indication: ___________________________ ICD-10 Code: ________________________

1. Dosing Regimen:
   <u>Crohn's Disease:</u> Infuse Stelara intravenously, diluted in Sodium Chloride 0.9% to final volume of 250 ml, over 60 minutes. Peripheral IV site with saline lock; may use existing PICC line or port-a-cath if available. Use infusion set with in-line, sterile, non-pyrogenic, low protein binding filter.

   Initial Dose (select one):

   ☐ 260 mg (wt ≤ 55 kg) once ☐ 390 mg (wt > 55 to 85 kg) once ☐ 520 mg (wt > 85 kg) once

   Maintenance Dose starting 8 weeks after initial dose (select one):

   ☐ Followed by Stelara 90 mg SQ every 8 weeks at the **infusion center**

   OR

   ☐ Followed by Stelara 90 mg SQ every 8 weeks, **patient to self-administer**

   ☐ Teaching to occur by infusion RN (provider's office to arrange patient receiving medication)

   <u>Psoriasis:</u>

   ☐ Adult patient weighs 100 kg or less: Stelara 45 mg SQ at Weeks 0 and 4, then every 12 weeks thereafter
   ☐ Adult patient weighs more than 100 kg: Stelara 90 mg SQ at Weeks 0 and 4, then every 12 weeks thereafter
   ☐ Adolescent: Stelara __________ mg SQ at Weeks 0 and 4, then every 12 weeks thereafter

   <u>Psoriatic Arthritis:</u>

   ☐ Adult patient: Stelara 45 mg SQ at Weeks 0 and 4, then every 12 weeks thereafter

   ☐ Adult patient with co-existent moderate-to-severe plaque psoriasis weighing more than 100 kg: Stelara 90 mg SQ at Weeks 0 and 4, then every 12 weeks thereafter

2. Vital signs: Initial, PRN

3. Pre-medications to be given 30 minutes prior to infusion (optional)

   ☐ OMG Infusion Center Pre-Medication Protocol
   <u>OR</u>
   ☐ Administer the following routine pre-medications prior to each infusion
   - ☐ Acetaminophen (Tylenol) 650 mg PO
   - ☐ Antihistamine (Select one)
     - ☐ Diphenhydramine (Benadryl) 25 mg PO
     - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
     - ☐ Loratadine (Claritin) 10 mg PO
   - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
   - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
   - ☐ Ondansetron 4 mg IV **<u>OR</u>** ☐ Ondansetron 8 mg IV

   ☐ Other: ____

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4. For infusion reaction (**Must select one to be considered a complete order**)

   ☐ Acute Infusion Reaction Protocol

   ☐ Other ____

A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: ______________________________________ Date: ____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: ___________________________________Time: ___________

Patient Name: ____DOB:____________