Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W. Horton Rd.
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight (kg): _____

IV Access: _____

Allergies: _____

Stelara (for Crohn's or UC) Order Form

- **Orders are initiated unless crossed out by provider.**

☐ **Check box to initiate order.**

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:
☐ Crohn's Disease ICD-10: _____
☐ Ulcerative Colitis ICD-10: _____
☐ Other: _____ ICD-10: _____

TB History: Date of last PPD test: _____ Result: _____

Medication Orders:

- Stelara (ustekinumab)

☐ **Induction**: Administer IV over at least one hour as a single dose. Use 0.2 micron in-line filter.
- Dose: ☐260 mg (<= 55 kg) ☐390 mg (>55 to 85 kg) ☐520 mg (>85 kg)

☐ **Maintenance**: Inject 90 mg subcutaneously every 8 weeks (starting 8 weeks after IV induction dose).

- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

☐ If no central IV access, RN to insert peripheral IV and rotate site as needed.
☐ Monitor for infusion reactions during IV induction dose, and for 30 minutes after infusion.
☐ RN to administer subQ injections, and train patient to self-inject if deemed clinically appropriate.
☐ Other: _____

_____

Labs:

☐ CBC with differential every _____
☐ _____ every _____
☐ _____ every _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name