

# Ustekinumab (STELARA and biosimilars)

**PROVIDERS: Please include the following information to expedite the order:**  
Patient demographics, insurance information, most recent visit notes, TB results, and applicable labs

## PATIENT INFORMATION

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
ICD-10: K50 K51 L40.0 L40.5 Other: \_\_\_\_\_ Description: \_\_\_\_\_  
Allergies: \_\_\_\_\_ NKDA Weight: \_\_\_\_\_ lb kg  
Patient Status:  New to Therapy  Continuation of Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## REFERRAL STATUS New Referral Updated Order Order Renewal

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## NURSING

- Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center
- Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures
- TB status and date (list results here and attach clinicals):  
\_\_\_\_\_

**Note to prescriber:** evaluate patients for active/latent infection prior to and periodically during treatment with ustekinumab

## LABORATORY ORDERS

- CBC at each dose every \_\_\_\_\_
- CMP at each dose every \_\_\_\_\_
- CRP at each dose every \_\_\_\_\_
- Other: \_\_\_\_\_
- Please check this box if you do NOT authorize Redeemer Health Infusion Therapy Center to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

## PRE-MEDICATION ORDERS

- acetaminophen (TYLENOL) 500 mg 650 mg 1000 mg PO
- cetirizine (ZYRTEC) 10 mg PO
- loratadine (CLARITIN) 10 mg PO
- diphenhydramine (BENADRYL) 25 mg 50 mg | PO IV
- methylprednisolone (SOLU-MEDROL) 40 mg IV 125 mg IV
- hydrocortisone (SOLU-CORTEF) 100 mg IV

## THERAPY ADMINISTRATION

- Ustekinumab  
**MUST SELECT PREFERRED PRODUCT.** If preferred product is not covered or the insurance company requires a specific alternative, we will contact your practice.
    - STELARA
    - Biosimilar (must indicate specific product): \_\_\_\_\_
  - Crohn's disease and Ulcerative colitis:**
    - Induction Dose:
      - 260 mg (55 kg or less)
      - 390 mg (>55 kg – 85 kg)
      - 520 mg (>85 kg)Administer one time IV over at least 1 hour in 250 mL of NS  
Flush with 0.9% sodium chloride after infusion complete
    - Maintenance Dose:  
90 mg SC every 8 weeks starting 8 weeks after IV induction dose
  - Refills:**  No Refills  12 months  \_\_\_\_\_
- All other indications:**
  - <100 kg: 45 mg SC at week 0, week 4, then every 12 weeks
  - ≥100 kg: 90 mg SC at week 0, week 4, then every 12 weeks
  - Other: \_\_\_\_\_
  - Refills:**  No Refills  12 months  \_\_\_\_\_

## SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.

Provider Name (Print): \_\_\_\_\_ Provider Signature (No Stamps): \_\_\_\_\_ Date: \_\_\_\_\_