Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

# STELARA® (USTEKINUMAB) PRESCRIBER ORDER FORM

**FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128**

☐ **NEW PATIENT OR**
☐ **CHANGE ORDER:** ◯ **Drug Change** ◯ **Dose Change** ◯ **Interval Change**

| | |
|---|---|
| Patient Name: | Date of Birth: |
| Phone: | Gender: |
| Address: | |
| Allergies: | |
| Height: ☐ in ☐ cm Weight: ☐ lbs ☐ kg | |

## CLINICAL INFORMATION

| | |
|---|---|
| **Primary Diagnosis Description:** | **ICD-10 Code:** |

**Is this the first dose?** ☐ Yes
☐ No – date of next dose due: _____

**Treatments – Tried and Failed:**

**TB Status:** ☐ PPD (negative) – date: _____ ☐ Active TB
☐ Last chest X-ray – date: _____ ☐ Other: _____
☐ Past positive TB infection, course taken: _____

## PRESCRIPTION

**Stelara® (Ustekinumab) refill as directed x 1 year**

Initial Dose: ☐ IV: Infuse over at least 1 hour once (check one): ☐ 260mg (up to 55kg) ☐ 390mg (>55kg to 85kg) ☐ 520mg (>85kg)
☐ SUBQ: Nurse to inject _____ mg SUBQ initially and repeat 4 weeks later.

Maintenance Dose: ☐ Nurse to inject _____ mg SUBQ every _____ weeks.

Next Dose Due Date: _____

## ANCILLARY ORDERS

**Pre-Medication Orders:**

☐ Acetaminophen 650mg PO 30 minutes before infusion.
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion.
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Other: _____

**PRN Hypersensitivity Meds:**

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:** **Date:**

## PRESCRIBER INFORMATION

| | | |
|---|---|---|
| **Prescriber Name:** | **Phone:** | **Fax:** |
| **Address:** | | **NPI:** |
| **City, State, Zip:** | **Office Contact:** | |