



St. Charles Health System

Adult Ambulatory Infusion Order
Ustekinumab (STELARA)
Or biosimilars

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____ kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE _____**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note
2. 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. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order. Patients should not have an active ongoing infection at the onset of ustekinumab therapy.
3. Monitor patients for signs / symptoms of active TB, infection, reversible posterior leukoencephalopathy syndrome (RPLS), and malignancy throughout therapy.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders
- Chest X-Ray result scanned with orders if TB test result is indeterminate

LABS:

- CBC auto differential, Routine, ONCE
- COMPLETE METABOLIC PANEL, Routine, ONCE

NURSING ORDERS

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
3. For signs and symptoms of active infection contact provider prior to administering.

MEDICATIONS

Biosimilar selection (must check one) – applies to all orders below

- WEZLANA (ustekinumab-auub) (St. Charles preferred brand)
- PYZCHIVA (ustekinumab-ttwe)



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- SELARDSI (ustekinumab-aekn)
- STELARA (ustekinumab)
- _____

At St. Charles, if insurance requires a different biosimilar agent, pharmacy will update the order per CDTM.

- Only check this box if it is NOT okay to substitute for insurance. Dispense as written (DAW).

Initial Dose:

- ustekinumab in sodium chloride 0.9 %, intravenous, ONCE, over 1 hour
 - Less than or equal to 55 kg 260 mg (two 130 mg vials)
 - Greater than 55 to 85 kg 390 mg (three 130 mg vials)
 - Greater than 85 kg 520 mg (four 130 mg vials)

Maintenance Dose:

GUIDELINE FOR ORDERING – Subcutaneous injections are included on the Center for Medicare & Medicaid Services Self-Administration Drug Exclusion List. An outpatient prescription for subcutaneous maintenance dosing will need to be supplied by the provider for patients with traditional Medicare (Medicare A/Medicare B) for self-administration.

AS NEEDED MEDICATIONS

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydramine (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebulizer, AS NEEDED x1 dose for hypersensitivity reaction



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Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed