Ustekinumab (Stelara) Induction
ORDER FORM

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine

Attach required documentation:

- ❑ H&P completed within last year.
- ❑ Documentation supporting diagnosis and prior therapies for diagnosis.
- ❑ Documentation of hepatitis B vaccination or testing.
- ❑ Documentation of tuberculosis (TB) testing – PPD or Quantiferon testing. Date of negative test:_____
- ❑ Patient is brought up to date with all immunizations before starting therapy.
- ❑ List of current medications and allergies.

Diagnosis: Patient weight _____ **kgs** Height _____ **inches**

☐ **Crohn's disease** ☐ **Ulcerative colitis**

ORDERS

1. PPD or IGRA before start of therapy if none in past 12 months. Notify provider of positive results.
2. CBC with differential; complete metabolic panel; C-reactive protein if none in past 30 days.
3. Serologic testing for **Hepatitis B** virus (Hepatitis B Surf Ag w/Rfx Conf, Hepatitis B Surface Antibody, Hepatitis B Core Ab Total) and **Hepatitis C** virus (Hep C Ab, Rfx Quant w/Genotype), **HIV** Antigen/Antibody 4th Gen.
4. Pregnancy test if between 14 and 50 years old with gestational potential.
5. Assess patient prior to each treatment for signs of infection or malignancy (especially skin cancer) ore recent vaccinations.
   Hold treatment and notify provider if symptoms of uncontrolled serious infections or live vaccines administered within 4 weeks of starting therapy.
6. Provide FDA medication guide prior to first dose.
7. **TREATMENT:** *Ustekinumab-kfce (Yesintek) will be administered unless otherwise required by insurer.*
   Ustekinumab IV as a single dose in Sodium Chloride 0.9% 250 mL (total volume with drug), infused over 1 hour via an in-line, low-protein binding filter (0.2 micrometer).
   Initial therapy: ≤55 kg: 260 mg (2 vials)
   >55 kg to 85 kg: 390 mg (3 vials)
   >85 kg: 520 mg (4 vials)
9. Anaphylaxis kit in unit and initiate per anaphylaxis policy if signs and symptoms of allergic reactions.
10. Vital signs pre and post infusion. Patient may be discharged if post-infusion vital signs are stable.
11. Educate patient about signs and symptoms of severe infections, and malignancy (especially skin cancer). Patient should expect to start self-injection with subcutaneous formula in 8-weeks. Offer education on subcutaneous injections, sharps container and proper disposal if not provided by prescribing office.

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Name:_____

Checklist for non-RFGH credentialed providers:

[ ] Problem list, current medication and allergies attached

[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .

Contacted provider:

FAX RFGH Infusion clinic at 207-858-2404 **Contact Infusion Clinic at 207-858-8722**

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____ Date_____ time_____

Printed name_____

Revised 6/25
Copy: rfgh.net
Originator: Pharmacy

Label or
Patient name_____

Date of birth_____

Patient phone number_____