Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Ustekinumab (Stelara) Order Set

Fill out all information on this form and attach the following as appropriate:

-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.

-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:	_____

Diagnosis		**ICD 10 Code(s)**		**J Code**	**CPT Code**
☐ Plaque Psoriasis ☐ Psoriatic Arthritis	☐ Crohn Disease ☐ Ulcerative Colitis ☐ Other: _____	☐ K50 ☐ K51 ☐ L40.9	☐ L40.53, L40.50 ☐ Other: _____	☑ J3357 for subcutaneous injection ☑ J3358 for IV injection	☑ CPT Code: _____

Labs (prior to scheduling infusion)	**Other Labs**
☑ TB Test	☐ _____

Nursing Orders	**Pre-medications (not required)**	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once ☐ Cetirizine 10 mg PO, once ☐ Dexamethasone 20 mg IV, once ☐ Ondansetron 4 mg IV, once	☐ Diphenhydramine 25 mg PO, once ☐ Diphenhydramine 25 mg IV, once ☐ Other: _____ ☐ Other: _____
Emergency/Anaphylaxis Order		
☑ Follow standard orders for management of allergies and anaphylaxis reactions		

Treatment for Psoriatic Arthritis or Plaque Psoriasis

	Medication	**Route**	**Dose**	**Frequency**	**Select Treatment Type**
☐	Ustekinumab	SQ	☐ 45 mg (actual body weight <100 kg) ☐ 90 mg (actual body weight >100 kg)	Once	☐ Initial: Every 4 weeks x 2 doses ☐ Maintenance: Every 12 weeks for ____ dose(s) ☐ Other: _____

Treatment for Crohn's Disease or Ulcerative Colitis

☐	Ustekinumab	☐ IVPB	☐ 260 mg (actual body weight ≤55 kg) ☐ 390 mg (actual body weight >55 to 85 kg) ☐ 520 mg (actual body weight >85 kg)	Once	☐ Initial: **IV** x 1 dose ☐ Maintenance: **SQ** every 8 weeks for ____ dose(s) ☐ Other: _____
		☐ SQ	☐ 90 mg		

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			