

**STELARA (USTEKINUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET**

Patient Information			
<b>Patient Name:</b>		<b>Date:</b>	
<b>DOB:</b>		<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm
<b>Allergies:</b>		<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Primary Diagnosis			
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<input type="checkbox"/> Crohn's Disease	K50.90	<input type="checkbox"/> Plaque Psoriasis	L40.0
<input type="checkbox"/> Ulcerative Colitis	K51.90	<input type="checkbox"/> Psoriatic Arthritis	L40.52
<input type="checkbox"/> Other:			

Medication Order	
<b>Stelara (Ustekinumab):</b> <b>Plaque Psoriasis or Psoriatic arthritis:</b> <input type="checkbox"/> Patients weighing < 100kg: 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks x 1 year <input type="checkbox"/> Patients weighing >100kg: 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks x 1 year <b>Crohn's Disease or Ulcerative Colitis:</b> <b>Initial Dosing:</b> <input type="checkbox"/> ≤55kg (<121 lbs.): 260mg IV over 1 hour x 1 dose <input type="checkbox"/> >55kg to 85kg: 390mg IV over 1 hour x 1 dose <input type="checkbox"/> >85 kg: 520mg IV over 1 hour x 1 dose	<input type="checkbox"/> Refills x one year from date of signature unless indicated below  <input type="checkbox"/> _____ Refills
<b>Initial Dosing:</b> <input type="checkbox"/> 90mg subQ 8 weeks after initial infusion every 8 weeks	

**Skilled nursing to assess and administer via access device as indicated below. Nursing will provide ongoing support as needed.**

Ancillary Orders (for IV Administration only)	
<b>Pre-medications:</b> <input type="checkbox"/> Diphenhydramine: 25mg PO 30 min pre-infusion <input type="checkbox"/> Acetaminophen: 650mg PO 30 min pre-infusion <input type="checkbox"/> Famotidine: 20 mg PO x1 dose <input type="checkbox"/> Other pre-meds: _____	<b>IV Flush Orders:</b> <input type="checkbox"/> Peripheral: NS 1-3 mL before/after use <input type="checkbox"/> Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush <input type="checkbox"/> CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw Heparin (10 units/mL) 3 to 5 mL final flush <input type="checkbox"/> Refill x one year
<input type="checkbox"/> <b>Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:</b> Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. <b>Refill x 1yr</b>	

Therapy Specific Documentation	Other Required Documentation
<b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b> <input type="checkbox"/> CMP, CBC, LFTs <input type="checkbox"/> Negative PPD <input type="checkbox"/> Hep B panel <input type="checkbox"/> Other: _____	<input type="checkbox"/> Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. <input type="checkbox"/> H&P OR progress note(s) <input type="checkbox"/> Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable

Provider Information	
<b>Provider Name:</b>	<b>Provider Phone:</b>
<b>Provider NPI:</b>	<b>Provider Fax:</b>
<b>Provider Address:</b>	

I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_