Stelara (ustekinumab)
Patient Referral and Prescription Sheet

KabaFusion
Patient-Focused Infusion Therapy

North Charleston, SC **Fax Completed Form To: 854.999.4977** **Phone: 888.211.7439**

Patient Information		
Patient Name:	**Date:**	
DOB:	**Height:**	❑ **inches** ❑ **cm**
Allergies:	**Weight:**	❑ **lbs** ❑ **kg**

Primary Diagnosis			
Diagnosis	**ICD-10**	**Diagnosis**	**ICD-10**
❑ Crohn's Disease	K50.90	❑ Plaque Psoriasis	L40.0
❑ Ulcerative Colitis	K51.90	❑ Psoriatic Arthritis	L40.52
❑ Other:			

Medication Order

Stelara (Ustekinumab):
Plaque Psoriasis or Psoriatic arthritis:
❑ Patients weighing < 100kg: 45mg subQ initially and 4 weeks later, followed by 45mg every 12 weeks x 1 year
❑ Patients weighing >100kg: 90mg subQ initially and 4 weeks later, followed by 90mg every 12 weeks x 1 year
Crohn's Disease or Ulcerative Colitis:
Initial Dosing:
❑ ≤55kg (<121 lbs.): 260mg IV over 1 hour x 1 dose
❑ >55kg to 85kg: 390mg IV over 1 hour x 1 dose
❑ >85 kg: 520mg IV over 1 hour x 1 dose

Initial Dosing:
❑ 90mg subQ 8 weeks after initial infusion every 8 weeks

❑ Refills x one year from date of signature unless indicated below

❑ _____ Refills

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*)

Pre-medications:
❑ Diphenhydramine: 25mg PO 30 min pre-infusion
❑ Acetaminophen: 650mg PO 30 min pre-infusion
❑ Famotidine: 20 mg PO x1 dose
❑ Other pre-meds: _____

IV Flush Orders:
❑ Peripheral: NS 1-3 mL before/after use
❑ 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
❑ 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
❑ **Refill x one year**

❑ **Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:** Adult: 0.3mg Children: 0.15 mg
Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. **Refill x 1yr**

Therapy Specific Documentation

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:
❑ CMP, CBC, LFTs
❑ Negative PPD
❑ Hep B panel
❑ Other: _____

Other Required Documentation

❑ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.
❑ H&P OR progress note(s)
❑ Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable

Provider Information	
Provider Name:	**Provider Phone:**
Provider NPI:	**Provider Fax:**
Provider Address:	

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: _____

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