ADULT AMBULATORY INFUSION ORDER

Ustekinumab (STELARA) Injection

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Weight: __________kg    Height: __________cm

Allergies: ____________________________

Diagnosis Code: ____________________________

Treatment Start Date: ___________    Patient to follow up with provider on date: ____________

**This plan will expire after 365 days at which time a new order will need to be placed**

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.
3. Patients should not have an active ongoing infection at the onset of ustekinumab therapy.
4. Patients should have regular monitoring for TB, infection, reversible posterior leukoencephalopathy syndrome (RPLS), and malignancy throughout therapy.
5. Select dose based on patient’s actual body weight
   a. Less than or equal to 100 kg: 45 mg/0.5 mL
   b. Greater than 100 kg: 90 mg/1 mL

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

□ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders

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:
- Ustekinumab (STELARA) injection, subcutaneous, ONCE. Administer injection into upper arm, upper thigh, abdomen, or buttocks. Rotate sites for each dose

**Initial Doses:**
- 45 mg
- 90 mg

**Interval:** *(must check one)*
- Once
- Two doses at 0, and 4 weeks; dates: Week 0 ________, Week 4 ________

**Maintenance Dose:**
- 45 mg
- 90 mg

**Interval:** *(must check one)*
- Every 12 weeks for _____ doses (Beginning at week 16)

**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

**HYPERSENSITIVITY MEDICATIONS:**
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in:  □ Oregon  □ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ___________________________  Date/Time: ___________________________
Printed Name: ___________________________  Phone: _____________  Fax: _____________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

□ Beaverton
   OHSU Knight Cancer Institute
   15700 SW Greystone Court
   Beaverton, OR 97006
   Phone number: 971-262-9000
   Fax number: 503-346-8058

 □ NW Portland
   Legacy Good Samaritan campus
   Medical Office Building 3, Suite 150
   1130 NW 22nd Ave.
   Portland, OR 97210
   Phone number: 971-262-9600
   Fax number: 503-346-8058

□ Gresham
   Legacy Mount Hood campus
   Medical Office Building 3, Suite 140
   24988 SE Stark
   Gresham, OR 97030
   Phone number: 971-262-9500
   Fax number: 503-346-8058

 □ Tualatin
   Legacy Meridian Park campus
   Medical Office Building 2, Suite 140
   19260 SW 65th Ave.
   Tualatin, OR 97062
   Phone number: 971-262-9700
   Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders