Spectrum Health

Physician's Orders USTEKINUMAB (STELARA) FOR CROHN'S DISEASE - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name

DOB

MRN

Physician

FIN

Defaults for orders not otherwise specified below:

- ☐ Interval: Every 56 days

Duration:

- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs. Verify that all INDUCTION/LOADING DOSES have been scheduled and offset appropriately when scheduling MAINTENANCE DOSES.

Provider Ordering Guidelines

☑ ONC PROVIDER REMINDER 15

USTEKINUMAB (STELERA) Crohn disease:

Tuberculosis surveillance and management: Screen prior to starting therapy. Treat latent infection prior to starting therapy.

Induction: IV:

Less than or equal to 55 kg: 260 mg as single dose

Greater than 55 kg to 85 kg: 390 mg as single dose

Greater than 85 kg: 520 mg as single dose

Maintenance: SubQ: 90 mg every 8 weeks; begin maintenance dosing 8 weeks after the IV induction dose.

Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6

Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5

TUBERCULOSIS SURVEILLANCE AND MANAGEMENT RECOMMENDATIONS: Screen prior to treatment. Treat latent infection prior to starting therapy.

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Patient Name
DOB
MRN
Physician
FIN

Labs

☑ **Arrange For Patient To Have Id Tb Skin Test Administered And Read Or Serum Tb Screening Lab Prior To Therapy Or Annually**

☑ ONC PROVIDER REMINDER 28
Arrange for patient to have intradermal TB skin test (tuberculin PPD) screening performed and read prior to initiating therapy and annually.

☑ TB Screen (Quantiferon Gold)
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

☐ Other Labs: _____ ☐ Once ☐ Every ____days ☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

Nursing Orders

☑ ONC NURSING COMMUNICATION 15
USTEKINUMAB (STELERA):

Hypersensitivity, including anaphylaxis and angioedema, has been reported. Discontinue immediately with signs/symptoms of hypersensitivity reaction and treat appropriately as indicated.

Monitor for signs/symptoms of infection, reversible posterior leukoencephalopathy syndrome (RPLS), and squamous cell skin carcinoma.

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

Treatment Parameters

☑ ONC MONITORING AND HOLD PARAMETERS 4
May proceed with treatment if tuberculosis screening test with either TB Screen blood test (QuantiFERON® Gold Plus) or TB skin test have been resulted prior to first dose and the results are negative.

Medications - Induction

	Interval	Duration
☑ ustekinumab (STELARA) in sodium chloride 0.9 % 250 mL IVPB	Once	1 treatment

Intravenous, for 1 Hours, Once, Starting S, For 1 Doses
Dose:
☐ 260 mg
☐ 390 mg
☐ 520 mg
Infuse over at least 1 hour; use of IV set with an in-line, low-protein binding filter (0.2 micrometer) required. Do not infuse concomitantly in the same IV line with other agents.

Medications – Maintenance

☑ ustekinumab (STELARA) 90 MG/ML injection 90 mg
90 mg, Subcutaneous, Once, Starting S, For 1 Doses
Administer by subcutaneous injection into the top of the thigh, abdomen, upper arms, or buttocks. Rotate sites. Do not inject into tender, bruised, erythematous, or indurated skin. Avoid areas of skin where psoriasis is present. Discard any unused portion. Intended for use under supervision of physician

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 09/13/20

