(ustekinumab)

STELARA IV Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____Crohn's Disease
☐ _____Other

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____Other

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____Other

STELARA IV ORDERS:

DOSAGE:

⬭ **Up to 55kg 260 mg (2 vials)**
⬭ **>55kg to 85kg 390mg (3 vials)**
⬭ **Greater than 85 kg 520mg (4 vials)**
● ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

PATIENT WEIGHT
_____LBS
_____KG

FREQUENCY:

⬭ **Initial infusion followed by SQ injections self-administered**
(follow-up maintenance injections to be coordinated by a specialty pharmacy and are not part of this order)

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Establish and maintain IV access / may use central venous access if appropriate and maintain per Specialty Infusion Center policy
- Flush IV with 3ml-5ml of saline before and after every IV medication and PRN
- Administer infusion medication/injection as ordered
- If mild itching, slow down the infusion and monitor patient closely
- If anaphylactic reaction, stop infusion, implement emergency medications, and plan and call 911
- When infusion complete, flush IV with 3ml to 5ml saline flush or 50ml bag of saline and discontinue IV per INS Standards
- Evaluate effectiveness of infused therapy on disease process
- Lab work per physician when ordered

ORDERING PROVIDER:

Signature _____ **Printed Name:** _____**Date**_____

Practice _____**Phone**_____ **Fax** _____

PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058