



(ustekinumab)

STELARA IV Infusion Orders

Patient Name _____ DOB _____ Gender: M F

Phone _____

DIAGNOSIS: *Please provide IDC-10 Code*

- _____ Crohn's Disease
- _____ Other

PRE-MEDICATION:

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ Other | <input type="checkbox"/> _____ 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)

PATIENT WEIGHT

_____ LBS
_____ KG

Emergency Orders and Treatment per Novello Infusion Anaphylaxis Policy

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 Novello 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 NOVELLO INFUSION 231-600-7058****