
 <p>Oregon Health & Science University Hospital and Clinics Provider's Orders</p> <p>PO9031</p>  <p>ADULT AMBULATORY INFUSION ORDER Ustekinumab (STELARA) for Psoriatic Indications Page 1 of 3</p>	<p>ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE</p> <p style="text-align: right;"><i>Patient Identification</i></p>
<p>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.</p>	

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. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. 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
- Chest X-Ray result scanned with orders if TB test result is indeterminate.

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, dec clotting (alteplase), and/or dressing changes.
3. For signs and symptoms of active infection contact provider prior to administering.



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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:

- acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
- diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:

- 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 (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
- diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
- EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
- hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
- famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction



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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: _____

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

Hillsboro Medical Center

Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123

Phone number: (503) 681-4124

Fax number: (503) 681-4120

Adventist Health Portland

Infusion Services
10123 SE Market St
Portland, OR 97216

Phone number: (503) 261-6631

Fax number: (503) 261-6756

Mid-Columbia Medical Center

Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058

Phone number: (541) 296-7585

Fax number: (541) 296-7610