



Oregon Health & Science University  
Hospital and Clinics Provider's Orders

PO9031



ADULT AMBULATORY INFUSION ORDER  
**Ustekinumab (STELARA) for  
Inflammatory Bowel Disease  
(Crohn's Disease and Ulcerative  
Colitis)**

Page 1 of 3

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

*Patient Identification*

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.**

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. Patients should not have an active ongoing infection at the onset of ustekinumab therapy.
3. Monitor patients for signs / symptoms of active TB, infection, reversible posterior leukoencephalopathy syndrome (RPLS), and malignancy throughout therapy.

**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.

**LABS:**

- CBC+DIFF, Routine, ONCE
- COMPLETE METABOLIC PANEL, Routine, ONCE

**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.

**MEDICATIONS:**

**Initial Dose:**

- ustekinumab (STELARA) in sodium chloride 0.9 %, intravenous, ONCE, over 1 hour
 

Less than or equal to 55 kg	<input type="checkbox"/> <b>260 mg</b> (two 130 mg vials)
Greater than 55-85 kg	<input type="checkbox"/> <b>390 mg</b> (three 130 mg vials)
Greater than 85 kg	<input type="checkbox"/> <b>520 mg</b> (four 130 mg vials)

**Maintenance Doses:** (starting 8 weeks after initial dose)

- ustekinumab (STELARA) 90 mg, subcutaneous, ONCE, every 8 weeks



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**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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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:** \_\_\_\_\_



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***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