nufactor®
A SPECIALTY INFUSION COMPANY

STELARA® (ustekinumab) Orders

For questions,
Call: (800) 323-6832
Fax: (855) 270-7347

Patient Information

Order Date:	Requested Start of Care Date:		Date of Birth:	
Patient name:		Height:	Weight: lb / kg	
Address:		City:	State:	Zip:
Primary Dx:			ICD-10:	
2° Dx:	ICD-10:	If IV Access: ◯ Periph ◯ Port ◯ Other:		
Allergies:				

Clinical History (complete upon initial referral only)

Prescribed drug use: ◯ Naive ◯ Transfer; on therapy since ___________ Past use, but not current Last dose: _________

Tuberculosis (testing recommended before start; most payers require annual testing)

Last TB test date: __________ TB test result: ☐ negative ☐ positive ☐ No current TB sx
If pending/ordered lab test, date: ________
If anti-TB therapy, drug(s) / date(s): ______________________________
☐ Currently on Stelara, no TB test within 12 months; OK to proceed with therapy

Meds tried & failed:		Meds contraindicated	

INTRAVENOUS: Stelara 130 mg/26 mL (5 mg/mL) single-dose vial
Check a dosing option

☐ Crohn's disease & ulcerative colitis dose per insert x 1 dose IV over at least 1 hour as tolerated unless otherwise specified: ______________________

Weight Range (kilograms)	Dosage
up to 55 kg	260 mg (2 vials)
greater than 55 kg to 85 kg	390 mg (3 vials)
greater than 85 kg	520 mg (4 vials)

☐ Dose: ______ mg IV over at least 1 hour as tolerated unless otherwise specified: ______________________
Frequency: ______________________________ Refills:__________

SUBCUTANEOUS: Stelara 45 mg/0.5 mL single-dose vial
Check a dosing option

☐ Crohn's disease & ulcerative colitis: 90 mg 8 weeks after the initial IV dose (if ordered), then every 8 weeks thereafter OR 90 mg every 8 weeks (if no IV dose ordered). Refill ____ months (unless noted, all prescriptions valid 1 year from date signed.)

☐ Dose: ______ mg Frequency: ______________________ Refill ____ months (unless noted, all prescriptions valid 1 year from date signed.)

Other Orders

Patient Type	Drug Description / Instructions - Dispense Quantity Sufficient
Stelara IV	• Sodium chloride 0.9% 250 ml bag: Use as directed to dilute & administer Stelara. • Sodium chloride 0.9% 100 ml bag: Use to flush gravity tubing with appx. 25 ml after dose to clear line of drug. ☐ Decline • If peripheral IV access for adult & pediatric >15kg: Sodium chloride 0.9% 10 ml syringe - Flush peripheral line pre/post with 1 – 3 ml.
Stelara IV or SC	• Lidocaine/prilocaine 2.5%/2.5% cream 30 gm (or other available size):Apply topically 60 min. pre-needle insertion prn discomfort ☐ Decline
Other Orders:	

Ancillary Supplies and DME Orders (Dispense quantity sufficient)

If SC: Ancillary supplies for Stelara administration. If IV: Ancillary supplies for Stelara administration, including a disposable IV pole, via peripheral IV, port, or indwelling central catheter via gravity.

Nursing Orders, as needed (not applicable if independent with therapy)

- Skilled Nursing Visits for education and teaching of Stelara side effects / management and administration.
- Nurse to administer Stelara and ancillary medications per physician orders.
- If Stelara IV: Nurse to obtain IV access via placement of peripheral IV or insertion of port needle when applicable. If IV access is not obtained after 3 attempts, nurse should contact Nufactor for assistance

Physician Information

Signature:	Name:
	NPI#:
	Address:
Date:	Phone: Fax: