NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

Ustekinumab (Stelara)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

- ☐ Adult Crohn Disease of small intestine, without complications (K50.00)
- ☐ Adult Crohn Disease of both small and large intestine, without complications (K50.80)
- ☐ Adult Crohn Disease, unspecified, without complications (K50.90)
- ☐ Adult Ulcerative Pancolitis, without complications (K51.00)
- ☐ Adult Ulcerative Colitis, unspecified (K51.90)
- ☐ Adult Ulcerative Colitis, other (K51.80)

Laboratory

☐ CBC WITH DIFFERENTIAL ☐ COMPREHENSIVE METABOLIC PANEL

Other: _____

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Infusion – Ustekinumab (Stelara) [J3358 : 1 MG = 1 unit]

FOR patient weighting 55 kg OR LESS

Ustekinumab (Stelara) 260 MG diluted in 0.9% Normal Saline Solution to a final volume of 250 mL INTRAVENOUS ONCE over 60 minutes

FOR patient weighting GREATER THAN 55 kg up to 85 kg

Ustekinumab (Stelara) 390 MG diluted in 0.9% Normal Saline Solution to a final volume of 250 mL INTRAVENOUS ONCE over 60 minutes

FOR patient weighting GREATER THAN 85 kg

Ustekinumab (Stelara) 520 MG diluted in 0.9% Normal Saline Solution to a final volume of 250 mL INTRAVENOUS ONCE over 60 minutes

If patient tolerates dose, may begin self-administering maintenance dosing at week 8

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

11212510

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES