LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

Stelara® (ustekinumab) Treatment Orders

Diagnosis (please provide ICD-10 code in space provided):

_____Crohn's Disease _____ Other: _____
(ICD-10) (ICD-10) (Description)

Nursing Orders: **Patient Weight:_____ kg**

☑ Hold treatment and notify provider for:
- Signs or symptoms of illness or active infection
- Cough, night sweats, unexplained weight loss
- Planned/recent surgical procedures
- Neurological changes
- Recent live vaccinations

☐ **Induction Dosing** (IV loading dose then SC):

☑ On Week 0, administer **Stelara** ☐ 260 mg (55 kg or less) ☐ 390 mg (56 to 85 kg) ☐ 520 mg (more than 85 kg)

Mix in 250ml 0.9% NaCl and infuse intravenously over 1 hour using an in-line, sterile, non-pyrogenic low-protein binding filter (pore size 0.2 micron).

☑ On Week 8, administer **Stelara 90 mg/ml** subcutaneously in the upper arm, abdomen or upper thigh.

☑ Repeat **Stelara 90 mg/ml** subcutaneously every 8 weeks.

☐ **Maintenance Dosing** (subcutaneous dosing only):

☑ Administer **Stelara 90 mg/ml** subcutaneously in the upper arm, abdomen or upper thigh every 8 weeks.

☐ **Other Dosing** (please specify):

Observation Period:
- Following *initial* Stelara treatment, observe patient for 15 minutes for hypersensitivity. Patients who have previously tolerated Stelara do not require observation period.
- If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.