PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

OUTPATIENT USTEKINUMAB (STELARA) ORDERS

Diagnosis: ☐ Severe plaque psoriasis
☐ Crohn's disease **ICD10:** _____

Verification of T SPOT/PPD or Quantiferon: TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: _____/_____/_____ Result: _____
Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____
PPD: Date: _____/_____/_____ Result: _____

IV Access:

☐ Saline Lock:
☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
☑ Discontinue Saline Lock after therapy completed
☐ PICC Line:
☑ Routine PICC Line Care, labs and restoration
☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
☐ Porta cath / Central Access Device (Hickman, Triple lumen):
☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

☐ Acetaminophen (Tylenol) *650 mg, PO, ONCE*
☐ Cetirizine (Zyrtec) *10 mg, PO, ONCE*

Medication:

☐ Wait for lab results before administering Ustekinumab (Stelara)

Dosing for Psoriasis:

☐ Ustekinumab (Stelara) *45 mg, Soln, subcutaneous, ONCE*
☐ Ustekinumab (Stelara) *90 mg, Soln, subcutaneous, ONCE*
☑ Repeat above dosing:
☐ *In 4 weeks, then*,
☐ *Every 12 weeks for 6 months*
☐ *Every 12 weeks for 1 year*

Dosing for Crohn's Disease:

Weight Range (kilogram)	Recommended 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)

☐ Ustekinumab (Stelara) *260 mg, Soln, IVPB, ONCE, Infuse over 1 hour*
☐ Ustekinumab (Stelara) *390 mg, Soln, IVPB, ONCE, Infuse over 1 hour*
☐ Ustekinumab (Stelara) *520 mg, Soln, IVPB, ONCE, Infuse over 1 hour*

Other: _____

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

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PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
July 2024