FUSIONDRIP
HYDRATION & WELLNESS

Stelara (ustekinumab) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ K50.90 – Crohn's disease, unspecified
☐ K50.80 – Crohn's disease of small and large intestine
☐ K51.90 – Ulcerative colitis, unspecified
☐ L40.0 – Plaque psoriasis
☐ L40.52 – Psoriatic arthritis
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- **Induction Dose (IV):**
  ☐
  ☐ 55–85 kg: 390 mg IV (3 vials)
  ☐ >85 kg: 520 mg IV (4 vials)
- ☐ Dilute in 250 mL 0.9% sodium chloride
- ☐ Infuse over ≥60 minutes using 0.2-micron in-line filter
- ☐ Observation: ☐ 30 minutes ☐ 60 minutes post-infusion
- ☐ Maintenance: 90 mg subcutaneous injection every 8 weeks (to begin 8 weeks after IV dose)
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☐ Fusiondrip Hydration & Wellness Center Protocol (fusiondriphydration.com)

☐ Other – please fax preferred reaction orders to 614-413-3877

☐ **Premedication (Optional)**
☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Famotidine: ☐ 20 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ ESR
☐ TB Screening (Quantiferon Gold or equivalent within 12 months)
☐ Hepatitis B Panel (HBsAg and anti-HBc)
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies or intolerance
☐ TB and Hepatitis B screening results

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____