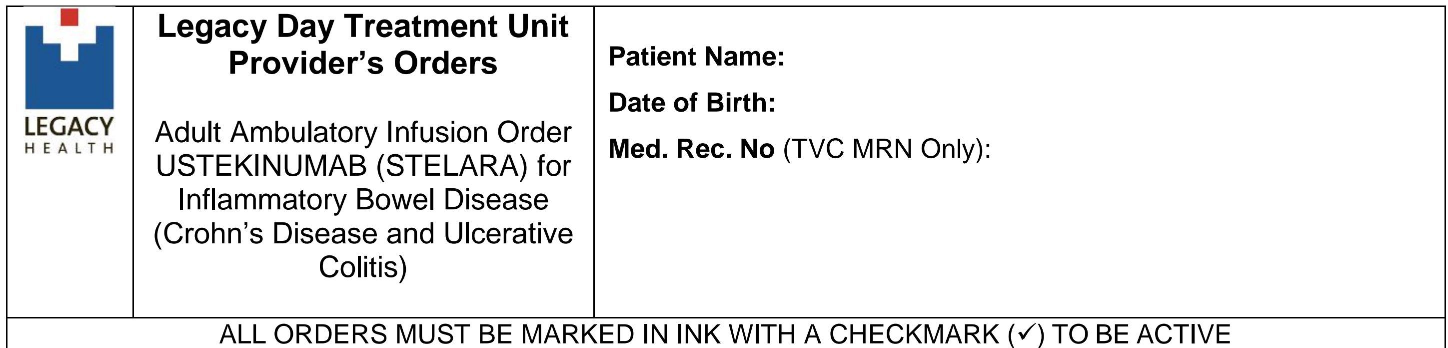


LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order USTEKINUMAB (STELARA) for Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: ___________ **Patient to follow up with provider on date:** ___________
*****This plan will expire after 365 days, unless otherwise specified below*****
Orders expire: ______________________

Weight: ___________kg **Height:** ___________cm

Allergies: ____

Diagnosis: ___________________

Diagnosis Code: ________________________ (**please include primary and secondary diagnosis codes)**

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order. Patients should not have an active ongoing infection at the onset of ustekinumab therapy.
3. Monitor patients for signs / symptoms of active TB, infection, reversible posterior leukoencephalopathy syndrome (RPLS), and malignancy throughout therapy.

PRE-SCREENING (Results must be available prior to initiation of therapy):

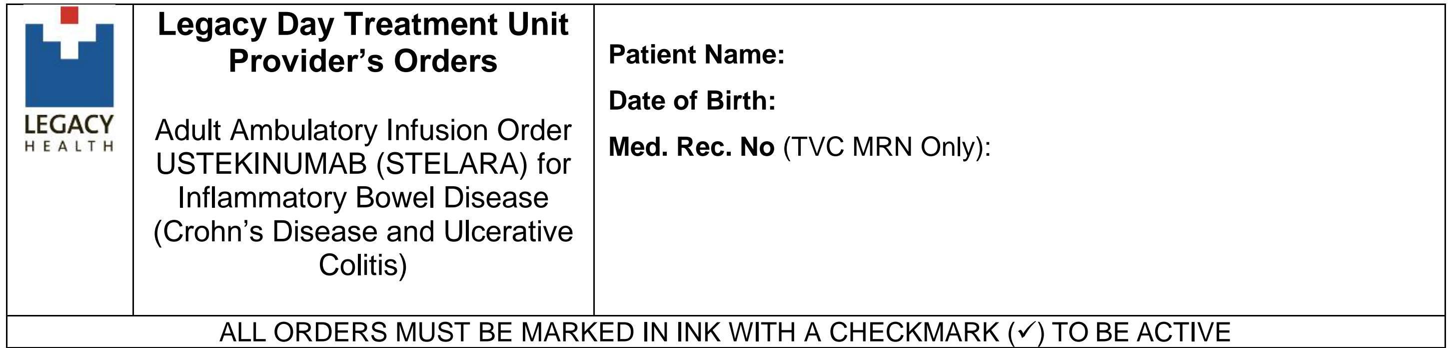
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-ray result scanned with orders if TB test result is indeterminate.

LABS TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):

- ☐ CBC with differential, Routine, ONCE
- ☐ CMP, Routine, ONCE

NURSING ORDERS (TREATMENT PARAMETERS):

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
3. For signs and symptoms of active infection contact provider prior to administering.Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters



LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order USTEKINUMAB (STELARA) for Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):

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MEDICATIONS:

☐ **Initial Dose:** Ustekinumab (STELARA) in sodium chloride 0.9%, intravenous, ONCE, over 1 hour

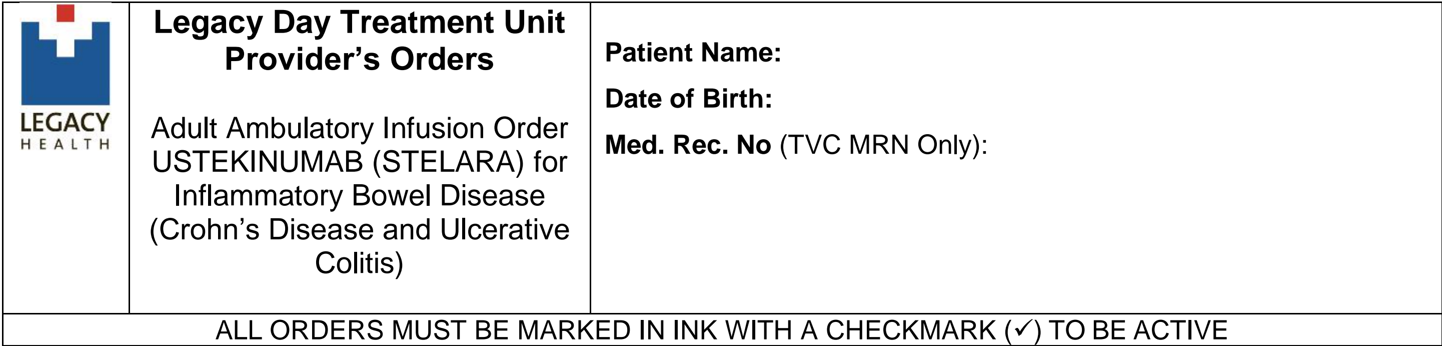
Less than or equal to 55 kg	☐ **260 mg** (two 130 mg vials)
Greater than 55-85 kg	☐ **390 mg** (three 130 mg vials)
Greater than 85 kg	☐ **520 mg** (four 130 mg vials)

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION - If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction



	Legacy Day Treatment Unit Provider's Orders Adult Ambulatory Infusion Order USTEKINUMAB (STELARA) for Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit – The Vancouver Clinic Building**
A department of Salmon Creek Medical Center
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
Legacy Salmon Creek Medical Center
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Woodburn STEPS Clinic**
A department of Silverton Medical Center
Legacy Woodburn Health Center
1475 Mt Hood Ave
Woodburn, OR 97071
Phone number: 503-982-1280
Fax number: 503-225-8723

☐ **Legacy Emanuel Day Treatment Unit**
A department of Emanuel Medical Center
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

Provider signature: ______________________________ **Date/Time:** ______________________

Printed Name: ____________________________ **Phone:** _______________ **Fax:** _____________

Organization/Department: ____