Memorial Healthcare System

USTEKINUMAB & BIOSIMILARS

PATIENT INFORMATION / REFERRAL STATUS

Referral Status: □ New Referral □ Updated Order □ Order Renewal **Date:** _____

Patient Name: _____ DOB: _____

ICD-10 Code: _____ ICD-10 Description/Diagnosis: _____

Allergies: □ NKDA Allergies: _____ Weight: _____ □ lbs/□ kg Height: _____

Patient Status: □ New to Therapy □ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER / PRACTICE INFORMATION

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Referral Coordinator Name: _____ Email: _____ Alternative Phone Number: _____

REFERRING PROVIDER COMMUNICATIONS

□ I have reviewed the prescribing information and medication guide for Ustekinumab (Stelara®), Ustekinumab-srlf (Imuldosa®), Ustekinumab-aauz (Otulfi®), Ustekinumab-ttwe (Pyzchiva®), Ustekinumab-aekn (Selarsdi®), Ustekinumab-hmny (Starjemza®), Ustekinumab-stba (Steqeyma®), Ustekinumab-auub (Wezlana®), Ustekinumab-kfce (Yesintek®).

- The appropriate dose should be determined by a healthcare provider using the patient's current weight at the time of dosing.
- IV Infusion is for the treatment of Ulcerative Colitis and Crohn's Disease in adults.
- Evaluate for active infection. Delay administration to patients with an active infection.
- STELARA may increase the risk of infections and reactivation of latent infections.
- Evaluate patients for malignancy (specifically skin cancer screening for patients who have a history of skin cancer or UV phototherapy).
- Avoid use of live vaccines during treatment. Prior to initiating therapy, complete all age appropriate vaccinations according to current immunization guidelines. BCG vaccines should not be given 1 year prior to, during, or 1 year following treatment.
- Latex: The needle cover on the prefilled syringe contains latex. The needle cover should not be handled by persons sensitive to latex.

NURSING PROTOCOL COMMUNICATIONS

☒ Provide nursing care, vital signs, monitoring according to Memorial Outpatient Procedures. Establish/maintain IV access and administer medication as ordered. Remove peripheral IV access after infusion completion if applicable. Follow infusion-related/hypersensitivity reactions management according to MHS Outpatient Adverse Reaction Protocol available for review on at mhs.net/services/pharmacy/infusion-services/outpatient-infusion.

☒ Discharge/Follow-up instructions according to Memorial Outpatient Procedures.

LABORATORY ORDERS

☐ ***Pregnancy, Urine for females of childbearing potential who have not undergone a hysterectomy:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☒ ***CBC with Diff:*** Every Visit

☒ ***Comprehensive Metabolic Panel:*** Every Visit

☐ ***CRP:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Hep B surface antigen [HBsAg]:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Hep B surf. antibody quantitative:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Hep B core antibody, total [anti-HBc]:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Liver panel:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Bilirubin fractionated:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☐ ***Vitamin D 25 hydroxy:*** ☐ Once ☐ Every Visit ☐ Every ____ months

☒ ***Quantiferon (R) TB gold, draw site incubated:*** ☒ Once ☐ Every Visit ☒ Every 12 months

PRE-MEDICATION ORDERS (30-60 Minutes Prior to Therapy)

☐ Acetaminophen (Tylenol) 650 mg PO

☐ Diphenhydramine (Benadryl) 25 mg PO **OR**

☐ Cetirizine (Zyrtec) or Loratadine (Claritin) 10 mg PO

☐ Methylprednisolone (Solu-Medrol) 125 mg IV, onetime, administer over 3-5 minutes, starting when released OR Administer 30 minutes prior to infusion, over 3-5 minutes **OR**

☐ Dexamethasone (Decadron) ☐ 8 mg ☐ 20 mg PO

☐ Other: _____ Dose: _____ Route: _____ Frequency/Timing: _____

THERAPY PLAN

Select Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis (UC)

Select Product (Check one):

☐ MHS Pharmacy to select product based on payor requirements, product availability, and indication.

☐ **OR Do Not Substitute and use product below:**

☐ Ustekinumab (Stelara)
☐ Ustekinumab-srlf (Imuldosa)
☐ Ustekinumab-aauz (Otulfi)
☐ Ustekinumab-ttwe (Pyzchiva)
☐ Ustekinumab-aekn (Selarsdi)
☐ Ustekinumab-hmny (Starjemza)
☐ Ustekinumab-stba (Steqeyma)
☐ Ustekinumab-auub (Wezlana)
☐ Ustekinumab-kfce (Yesintek)

Dose:

Body Weight of Patient at the Time of Dosing	Dose
55 kg or less	260 mg
55.1 kg to 85 kg	390 mg
Greater than 85 kg	520 mg

Route: ☒ IV ☐ SQ ☐ IM

Infuse over: ☐ 30 minutes ☒ 1 Hour ☐ 2 Hours ☐ Other:_____

Frequency: Once

Diluent/Volume/Concentration/Special tubing/Filters will be in accordance with the product package insert.*

☒ Flush with 0.9% sodium chloride at completion per protocol or medication-specific instructions

Additional Administration Instructions:
Use of IV set with an in-line, low-protein binding filter (0.2 micrometer) required. Do not infuse concomitantly in the same IV line with other agents.

Note to Pharmacy/Comments:

Restricted to outpatient use.

Refills: ☐ Zero ☐ for 12 months ☐ Other:_____

(if not indicated, order will expire one year from date signed)

_____ _____ _____

Provider Name (Print) ***Provider Signature*** ***Date***

Memorial Healthcare System

Adverse Reaction Management Protocol (Adult)

Observe patient for infusion related and hypersensitivity reactions such as fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting.

If reaction occurs:

- Stop infusion and assess patient.
- Maintain or establish vascular access if needed
- **Administer emergency medication(s) according to symptoms:**

☒ Acetaminophen 650 mg PO once PRN headache, pain, fever >100.4F, chills or rigors.

☒ Diphenhydramine 50 mg IV once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction **OR**

☒ Diphenhydramine 50 mg IM once PRN itching, allergies, infusion reaction, hives, pruritic and other nonspecific symptoms of allergic reaction (if no IV access)

☒ Dexamethasone 10 mg IV once PRN shortness of breath or wheezing **OR**

☒ Dexamethasone 10 mg IM once PRN shortness of breath or wheezing (if no IV access)

☒ Ondansetron 4 mg IV once PRN nausea, vomiting **OR**

☒ Ondansetron 4 mg IM once PRN nausea, vomiting (if no IV access)

- May re-start therapy if appropriate when symptoms resolve. Resume infusion at 50% of the previous rate and increase per manufacturer's guidelines.

If a severe allergic/anaphylactic reaction occurs

- Symptoms are rapidly progressing or continuing after administration of PRN medications and/or signs and symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension)

☒ Notify the Rapid Response / Rescue Alert Team / Blue Alert / 911.

☒ Initiate BLS/ Cardiopulmonary resuscitation if necessary.

☒ Administer Epinephrine 0.3 mg intramuscularly, every 5 MIN PRN rapidly progressing or continuing after administration of PRN medication or signs and symptoms of severe allergic/anaphylactic reaction. Administer every 5-15 minutes as needed preferably in the outer thigh.

☒ Place the patient in a recumbent position, elevate lower extremities.

☒ Continuously monitor vital signs (blood pressure, pulse oximetry, and heart rate).

☒ Contact and notify the referring provider on the day of occurrence once patient is stabilized.

☒ Document reaction in the medical record and complete an incident report once patient is stabilized.