CoxHealth at Home

CoxHealth

# Stelara ®

(ustekinumab)

Phone: 1-855-419-4663

Fax: 1-417-269-0692

## Patient Information

Name:_____ DOB:_____

Height: _____ ❑ in ❑ cm Weight_____ ❑ kg ❑ lbs

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Alternate:_____

SSN:_____

**PLEASE INCLUDE ON FAX A COPY OF FRONT AND BACK OF INSURANCE CARD(S)**

## Prescriber

Prescriber name:_____

NPI: _____

Address:_____

_____

City:_____ State:_____ Zip:_____

Contact:_____

Phone:_____ Fax:_____

## Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: Diagnosis: ❑ K50.90 (Crohn's disease) ❑ K51.0 (Ulcerative colitis)

❑ Other: _____

Allergies:_____

## Intravenous Stelara®

**Flushing/Premedication Orders:**

✓ Flushing per CoxHealth at Home protocol

- ✓ PIV: 0.9% sodium chloride 3-20mL before and after infusion as needed
- ✓ Port: 0.9% sodium chloride 3-20mL into port at time of access or at least monthly, 0.9% sodium chloride 3-20mL before and after infusion as needed, Heparin 100 units/mL 5mL as lock after infusion

✓ No routine premedication necessary. If desired, please write here: _____

**Stelara® (ustekinumab)** IV over 60 minutes

**Frequency:** ✔ ONCE (to be followed in 8 weeks by 90 mg subcutaneously every 8 weeks)

**Dose:** If no dose is selected below, RPh to select dose using weight listed above.

Dilute in 0.9% sodium chloride to a total volume of 250mL.

❑ less than 55kg: 260mg ❑ ≥ 55 kg to 85kg 390mg ❑ > 85kg: 520mg

**Quantity to dispense:** 1 dose

**Stelara® (ustekinumab)** 90mg subcutaneously 8 weeks after IV dose then every 8 weeks thereafter

**Quantity to dispense:** 1 syringe with 6 refills (1 year) or _____ refills.

**CoxHealth at Home nursing to provide injection teaching if needed.**

**Labs:**_____ (to be drawn: ❑ prior to infusion OR ❑ prior to subcutaneous injection teaching)

Prescriber's Signature:_____ Date_____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.