

<b>1 PATIENT INFORMATION</b> Patient Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ MRN #: _____ DOB: _____ Drug Allergies: _____	<b>2 PRESCRIBER INFORMATION</b> Prescriber's Name: _____ DEA#: _____ NPI: _____ Clinic/Facility Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____
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**3 Instructions to Provider**  
 All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice>.

**4 CLINICAL INFORMATION**  
 Diagnosis (ICD-10 code): \_\_\_\_\_ Date of Last Dose: \_\_\_\_\_

**5 USTEKINUMAB-KFCE PRESCRIPTION INFORMATION**

**Ustekinumab-kfce (YESINTEK) in 0.9% Sodium Chloride 250 ml IV Infusion** Route: Intravenous

TB Status:  PPD (negative) Date: \_\_\_\_\_  Last Chest X-Ray: Date \_\_\_\_\_  Active TB:  Unknown

Weight: \_\_\_\_\_ kg Date: \_\_\_\_\_

Induction Dose:  260 mg  390 mg  520 mg

- Dosing guidelines for adults: Less than 55 kg: 260 mg; 55 to 85 kg: 390 mg; 85 kg or greater: 520 mg

**Sig: Infuse ustekinumab-kfce through an intravenous catheter ONCE.**  
 (Maintenance subcutaneous dose to be filled at specialty pharmacy. Please send prescription to specialty pharmacy.)

First Dose:  No  Yes

Refills: \_\_\_\_\_ Infusion Access:  PIV  CVAD  Other: \_\_\_\_\_

Patient's Current Home Care/Specialty Pharmacy: \_\_\_\_\_

Infusion Rate: Infuse over 60 minutes at 250 ml/hr.

**Infusion Reaction Medications & Supplies**

<ul style="list-style-type: none"> <li>✓ <b>Hydrocortisone sodium succinate injectable 100 mg IV</b> Sig: Once PRN for hypersensitivity</li> <li>✓ <b>Epinephrine Auto-Injector</b> <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg QTY: 2 Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.</li> <li>✓ <b>Sodium Chloride 0.9% IV Flush:</b> Flush 10 ml IV before/after medication administration or as needed for line maintenance</li> </ul>	<ul style="list-style-type: none"> <li>✓ <b>Diphenhydramine injectable 25 mg IV</b> Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath</li> <li>✓ <b>Sodium Chloride 0.9% IV 250 ml Bag</b> Sig: Once PRN for anaphylaxis</li> </ul>
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**Labs /Special Instructions/Pre-meds:** \_\_\_\_\_

<b>Infusion Protocol:</b> <ul style="list-style-type: none"> <li>• Infuse per manufacturer guidelines</li> <li>• Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion</li> <li>• Documentation must include:                             <ul style="list-style-type: none"> <li>○ Start and end time of infusion</li> <li>○ All rate changes, vital signs, including initial and final set</li> <li>○ Patient response</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Observe patient for signs of infusion rate-related adverse reactions:                             <ul style="list-style-type: none"> <li>○ Blood pressure changes, increased pulse rate</li> <li>○ Fever, chills</li> <li>○ Headache</li> <li>○ Chest, back or hip pain</li> <li>○ Dyspnea</li> <li>○ Mild erythema</li> </ul> </li> </ul>
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**6 PHYSICIAN SIGNATURE REQUIRED**

X _____ SUBSTITUTION PERMITTED (Date)	X _____ DISPENSE AS WRITTEN (Date)
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