KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Ustekinumab (STELARA) – Induction
Infusion Therapy Plan Orders

Instructions to Provider

Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

Order Date: _____

Weight: _____kg

Diagnosis:

ICD-10 code *(REQUIRED):* _____

ICD-10 description_____

_____

General Plan Communication

- Induction Schedule: Infuse ustekinumab loading dose once.
- Maintenance Schedule: Inject 90 mg ustekinumab subcutaneously every 8 weeks, starting 8 weeks after induction infusion.
- Special instructions/notes: _____

Provider Information

- Ensure baseline PPD or quantiFERON-TB assay are negative for latent TB.
- Treatment with ustekinumab not recommended in patients with active, severe infections. Consider withholding ustekinumab in patients who develop a severe infection while on treatment.
- Ensure an immunization plan is in place before initiating therapy.
- Live vaccines should not be given concurrently or within 1 month prior to initiation of therapy. BCG vaccine should not be administered 1 year prior to initiation or 1 year following discontinuation of therapy.
- Risk of developing Reversible Posterior Leukoencephalopathy Syndrome (RPLS): Monitor for new or worsening neurological signs or symptoms
- Dosing guidelines for adults: Less than 55 kg: 260 mg; 55 to 85 kg: 390 mg; 85 kg or greater: 520 mg

Infusion Therapy

☑ **Ustekinumab (STELARA) in 0.9% sodium chloride 250 mL IV infusion**

Dose: ☐ **260 mg** ☐ **390 mg** ☐ **520 mg**

Route: Intravenous

Frequency: **Once**

Infusion Rate: Infuse over 60 minutes, starting 60 minutes after treatment start time

If infusion-related reaction:

1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

Note any changes to above regimen: _____

Pre-Meds

☑ No routine pre-medications necessary. Above pre-meds may be given if patient has a reaction.

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL

Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open

Start peripheral IV if no central line

Infusion Reaction Meds

☑ albuterol (ACCUNEB) nebulizer solution

Dose: 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg *Route:* Intravenous *Frequency:* Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify MD if administered.

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose : 125 mg *Route* : IV push *Frequency:* Once PRN for hypersensitivity reaction. Notify MD if administered.

Lab Review for Nursing

- Ensure CBC, ALT, AST, and Creatinine have been drawn within the last 16 weeks.
- If labs have not been drawn within 16 weeks, proceed with infusion and instruct patient to receive lab draw today.
- If patient has not had labs drawn within 20 weeks, hold infusion and notify provider.

Nursing Orders

- *Initial dose only:* Verify PPD or quantiFERON-TB assay for latent TB results are negative for TB. Verify HBV sAg and cAb labs have been completed by the ordering provider. Do not infuse STELARA without negative TB, HBV sAg, and HBV cAb results. Notify provider if positive result.
- Administer using a low protein-binding 0.2 micron filter.
- Monitor patient for hypersensitivity reaction: urticaria, dizziness, fever, rash, rigors, pruritus, nausea, flushing, hypotension, dyspnea, and/or chest pain.
- Discontinue IV line when therapy complete and patient stabilized.

References

- STELARA® Prescribing Information. Revised July 2022.

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3811 Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104 Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7092 Phone: 360-923-7164

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-324-7168 Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-3665 Phone: 253-596-3666

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____