

INFUSION SUITE		STELARA INFUSION/INJECTION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
<b>PATIENT INFORMATION - Include Patient Demographics and Insurance Cards</b>			
Name:		DOB:	
<b>MEDICAL INFORMATION</b>			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
<b>REQUIRED TESTING</b>			
<input type="checkbox"/> TB: _____ *Prior to initiation			
Additional labs:			
<input type="checkbox"/> Insert IV	<input type="checkbox"/> Access Port/PICC		
<b>PREMEDICATIONS 30 minutes prior to starting</b>			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Methylprednisolone:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:			
<b>STELARA ORDERS</b>			<i>*IV for UC or Crohn's only</i>
<input type="checkbox"/> Initial:	<input type="checkbox"/> 260mg (less than 55kg) IV in 250mL NS over 60 minutes X 1		
	<input type="checkbox"/> 390mg (55kg-85kg) IV in 250mL NS over 60 minutes X 1		
	<input type="checkbox"/> 520mg IV (over 85kg) in 250mL NS over 60 minutes X 1		
<input type="checkbox"/> Subsequent:	90mg subcutaneous every 8 weeks X _____		
<input type="checkbox"/> Psoriasis: Over 100kg:	90 mg subcutaneous week 0, Week 4, then every 12 weeks X _____		
<input type="checkbox"/> Psoriasis: Under 100kg:	45mg subcutaneous week 0, Week 4, then every 12 weeks X _____		
<input type="checkbox"/> PsA	45mg subcutaneous week 0, Week 4, then every 12 weeks X _____		
<b>POST INFUSION</b>			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge home			
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

*\*Credentials must be included*

**Table 3: Initial Intravenous Dosage of STELARA®**

Body Weight of Patient at the time of dosing	Dose	Number of 130 mg/26 mL (5 mg/mL) STELARA® vials
55 kg or less	260 mg	2
more than 55 kg to 85 kg	390 mg	3
more than 85 kg	520 mg	4

**Infusion Directions:**

- Bring vials to room temperature (no longer than 4 hours)
- Use a 250mL NS bag; remove the volume of NS to equal the required dose of Stelara to be added
  - o for 2 vials discard 52mL NS
  - o for 3 vials discard 78mL NS
  - o for 4 vials discard 104mL NS)
- Withdraw 26mL of Stelara from each vial needed and add it to the 250mL NS bag, gently invert to mix.
- Discard and document drug waste
- Infuse over 60 minutes using an infusion set with a 0.2 or 0.22 micron in-line filter