STELARA (USTEKINUMAB) Order Set

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Diagnosis: ☐ Plaque psoriasis ☐ Psoriatic arthritis **ICD-10 Code:** _____

Stelara (adult dosing):

☐ Patients weighing <100kg (220lbs), 45 mg Sub-Q initially and 4 weeks later, followed by 45 mg every 12 weeks x1 year

☐ Patients weighing >100kg (220lbs), 90 mg Sub-Q initially and 4 weeks later, followed by 90 mg every 12 weeks x1 year

☐ Other: _____

Diagnosis: ☐ Crohn's disease ☐ Ulcerative colitis **ICD-10 Code:** _____

Stelara (adult dosing):

Initial Infusion: ☐ ≤55kg (<121lbs), 260 mg IV over 1 hour x1 dose

☐ >55kg-85kg (>121lbs-187lbs), 390 mg IV over 1 hour x1 dose

☐ >85kg (>187lbs), 520 mg IV over 1 hour x1 dose

Maintenance: ☐ 90 mg Sub-Q 8 weeks after initial infusion, then refill every 8 weeks for 1 year, for a total of 6 refills

Lab Orders: _____ **Lab Frequency:** _____

☐ Yearly TB QFT test (optional) Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Other orders: _____

Anaphylactic reaction orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

COMPREHENSIVE SUPPORT FOR STELARA (USTEKINUMAB) THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID or conventional therapy (i.e., MTX, 6-MP)?
  - ☐ Yes ☐ No
  - If yes, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Otezla, Stelara, Cimzia)?
  - ☐ Yes ☐ No
  - If yes, which drug(s)? _____
- ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %
- ☐ If psoriasis diagnosis, Psoriasis Area and Severity Index (PASI) score: _____

☐ Include labs and/or test results to support diagnosis

☐ *If applicable* – Last known biological therapy: _____ and last date received: _____ .

If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting Stelara.

☐ Other medical necessity: _____

Required Prescreening

☐ **TB screening test completed within 12 months – attach results**

- ☐ **Positive** ☐ **Negative**

*If TB results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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