



Trinity Health Muskegon & Shelby Infusion Clinics

Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444

Shelby: 72 S. State St. Shelby, MI 49455

Fax (shared): 231-672-3970

Ustekinumab (Stelara®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ___/___/___ Site of Service: TH Muskegon TH Shelby (SubQ only)

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: ___/___/___ Weight: ___kg Height: ___cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____																		
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	Labs <input type="checkbox"/> Interferon gamma for TB, whole blood <input type="checkbox"/> CBC and differential																		
Date of negative Tuberculosis Screen: _____ Date of Negative Hepatitis Screen: _____																			
Hold and notify provider: Patient has signs/symptoms of an active serious infection.																			
Pre-medications: No routine pre-medications are routinely given. Pre-medications may be ordered at physician discretion.																			
<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Acetaminophen</td> <td>650mg</td> <td>Oral</td> </tr> <tr> <td><input type="checkbox"/> Loratadine</td> <td>10mg</td> <td>Oral</td> </tr> <tr> <td><input type="checkbox"/> Diphenhydramine</td> <td>50mg</td> <td><input type="checkbox"/> Oral <input type="checkbox"/> IV</td> </tr> <tr> <td><input type="checkbox"/> Famotidine</td> <td>20mg</td> <td><input type="checkbox"/> Oral <input type="checkbox"/> IV</td> </tr> <tr> <td><input type="checkbox"/> Hydrocortisone</td> <td>100mg</td> <td>IV</td> </tr> <tr> <td><input type="checkbox"/> Methylprednisolone</td> <td>125mg</td> <td>IV</td> </tr> </table>		<input type="checkbox"/> Acetaminophen	650mg	Oral	<input type="checkbox"/> Loratadine	10mg	Oral	<input type="checkbox"/> Diphenhydramine	50mg	<input type="checkbox"/> Oral <input type="checkbox"/> IV	<input type="checkbox"/> Famotidine	20mg	<input type="checkbox"/> Oral <input type="checkbox"/> IV	<input type="checkbox"/> Hydrocortisone	100mg	IV	<input type="checkbox"/> Methylprednisolone	125mg	IV
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Crohn's Disease and Ulcerative Colitis <u>Induction Therapy (IV)</u> < 55 kg: <input type="checkbox"/> 260mg once >55 kg to 85 kg: <input type="checkbox"/> 390mg >85 kg: <input type="checkbox"/> 520 mg <u>Maintenance Therapy (SubQ)</u> <input type="checkbox"/> 90 mg every 8 weeks; begin maintenance dosing 8 weeks after the IV induction dose	Plaques Psoriasis ≤100 kg (SubQ): <input type="checkbox"/> 45 mg at 0 and 4 weeks, and then every 12 weeks thereafter. >100 kg (SubQ): <input type="checkbox"/> 90 mg at 0 and 4 weeks, and then every 12 weeks thereafter. Psoriatic Arthritis Initial and maintenance (SubQ): <input type="checkbox"/> 45 mg at 0 and 4 weeks, and then every 12 weeks thereafter.																		
Nursing Orders Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary. sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN.																			
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i>	Provider Signature: _____ Office Fax Number: _____																		