Update May 26, 2020

Checklist for Stelara (ustekinumab) Administration for Crohn's and UC Referral

Required documentation for all initial referrals

Patient _____DOB_____ Date_____

Please return **completed** checklist and checklist items for an infusion referral:

- ☐ Patient demographics (e.g. address, phone number, SSN, etc.)
- ☐ Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber's date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- ☐ Signed and completed Stelara Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Stelara.
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required TB screening results**: PPD *(within 1 year)* or QuantiFERON Gold Test *(within 3 years)*
    - **Required Hepatitis screening *(within 1 year)***: Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, and Hepatitis B Core Antibody results
- ☐ Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: _____
  - Phone Number: _____

Paperwork can be faxed to (843)-793-6181

Infusion Coordinators can assist you with any questions at
(843)-572-8932

Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

Summerville
2001 2nd Ave, Suite 201, Summerville, SC 29486

Mount Pleasant
1100 Johnnie Dodds Blvd, Mt. Pleasant, SC 29464

West Ashley
2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our NP to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Low Country Rheumatology Use Only Existing Patient Yes____ No____ Physician _____

Update May 26, 2020

Standard Orders for Stelara (ustekinumab) Administration for Crohn's and UC

Patient _____DOB_____ Date_____

***NOTE**: Patient is ineligible to receive Stelara if they have suspected infectious process.

Indication:

□ K50.90 Moderate to severe Crohn's disease	□ K51.90 Ulcerative Colitis

History:

□ Inadequate response or intolerance to Immunomodulators (list)_____

□ Recent or upcoming surgery? □ Yes □No

□ HBsAg, HBsAb, HB core Ab, and HCAb, Quantiferon, PPD or Tspot □Neg (send copies of results)

Orders:

□ Standard Order Protocol:

- Confirm current PPD, Tspot, or CXR;
- Confirm HBsAg, HBsAb, HB core Ab, and HCAb negative
- Obtain patient weight
- Evaluate patient for active infections, prior or upcoming surgical procedures, medication allergies or any current health concerns as noted on Infusion Record
- Baseline vitals will be obtained prior to administration, and at the end of the infusion (or hourly if infusion > 1-hour length until infusion is complete) and more frequently if patient's condition warrants it.
- **If infusion reaction occurs, slow or stop infusion, and initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
- Discharge instructions to include possible infusion side effects and follow-up appointment schedule

Dose: Single IV Dose

□ Up to 55 kg 260 mg (2 vials)
□ Greater than 55 kg to 85 kg 390 mg (3 vials)
□ Greater than 85 kg 520 mg (4 vials)

Subsequent SQ doses (for administration in infusion suite)

□ Patient will self-inject subsequent doses
□ 90mg SQ 8 weeks after IV dose then every 8 weeks

Rate

- Infuse over one hour using IV tubing with 0.2 micrometer filter

Premedicate:

PRN pre-medication:

□ No premedication
□ 1000 mg Acetaminophen PO □ 25mg Benadryl PO/IV □ 125mg Solu-Medrol IV □ Other _____

Infusion Reaction protocol as needed

Additional orders/comments:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____