BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

USTEKINUMAB ORDERS (IV)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC w/diff/CMP/TB/HepB/CRP lab results
☐ Some payors may require HepC and HIV testing
☐ For UC/CD dx: include colonoscopy reports and pathology reports
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐PIV ☐PICC ☐Port ☐Other:

DIAGNOSIS

☐Dx code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics and insurance info ☐ H&P, labs, tests, progress notes supporting dx

☐Hepatitis B Screening: ☐Positive ☐Negative-Date:	☐TB Screening: ☐Positive ☐Negative-Date:
• Prior Therapies:	

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐CMP ☐CBCwdiff ☐CRP ☐Sed Rate ☐Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐650mgPO ☐1000mgPO	Methylprednisolone: ☐100mgIV ☐125mgIV ☐ mgIV
Diphenhydramine: ☐25mgPO ☐50mgPO ☐25mgIV ☐50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐**Ustekinumab** Induction dose for UC&CD	130mg/26mL	☐10mg/kg (PEDS 10-25kg) Dilute in 100ml 0.9%NS total volume, infuse IV over 60 minutes x 1	☐# sufficient for weight-based dose Refills: none
☐**Specific Product (optional):**		☐260mg (PEDS 25kg-55kg, ADULTS≤55kg) ☐390mg (>55-85kg) ☐520mg (>85kg) Dilute in 250ml 0.9%NS total volume infuse IV over 60 minutes x 1	☐2 vials ☐3 vials ☐4 vials Refills: none

If no product is specified, an insurance-preferred biosimilar may be used.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐**Product Substitution Permitted** ☐**Dispense as Written**

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