Atrium Health Wake Forest Baptist

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Wake Forest Baptist Infusion - Westchester **Fax 336-802-2389**

Ustekinumab or Biosimilar Infusion Order (Revised 08/25/2026)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ K50.0____ - Crohn's disease (small intestine)	☐ K51.2____ - Ulcerative (chronic) proctitis
☐ K50.1____ - Crohn's disease (large intestine)	☐ K51.3____ - Ulcerative (chronic) rectosigmoiditis
☐ K50.8____ - Crohn's disease (small and large intestine)	☐ K51.5____ - Left sided colitis
☐ K50.9____ - Crohn's disease, unspecified	☐ K51.8____ - Other ulcerative colitis
☐ K51.0____ - Ulcerative (chronic) pancolitis	☐ K51.9____ - Ulcerative colitis, unspecified
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required Lab Results: (**Fax labs with order**)
- Hep B Profile and PPD/Quantiferon Gold PRIOR to first treatment.

☑ Hold Treatment and Notify Provider IF:
- Hep B Profile: POSITIVE result or not on file;
- PPD/ Quantiferon Gold: POSITIVE or not on file.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.
☑ Monitor for any signs of reaction or side effects for 30 minutes POST-treatment.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Hydrocortisone sodium succinate (Solu-Cortef) 100mg IV ONCE
☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Ustekinumab or Biosimilar Infusion:

☐ 260mg IV (LESS THAN 55kg) ONCE over 60 minutes	☐ 390mg IV (55-85kg) ONCE over 60 minutes
☐ 520mg IV (>85kg) ONCE over 60 minutes	

Infuse using an in-line protein 0.2-micrometer filter.

☑ **Atrium Health will authorize the payer preferred ustekinumab productPlease list any contraindicated ustekinumab product:Please list the reason for the contraindication:**

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health Wake Forest Baptist approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Wake Forest Baptist Infusion - Westchester website at www.wakehealth.edu/locations/clinics/i/infusion-westchester

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: