

TREMFYA® (GUSELKUMAB) PRESCRIBER ORDER FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code: _____

TB Status: PPD (negative) – date: _____ Active TB
 Last chest x-ray – date: _____ Unknown
 Quantiferon or T Spot Assay result and date: _____ Past positive TB infection, course taken: _____

TREMFYA® (guselkumab) Prescription

TREMFYA® (guselkumab) refill as directed x 1 year

Ulcerative Colitis

Induction IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8
Maintenance SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter.
 SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.

Crohn's Disease

Induction IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8
 SubQ: Inject 400mg at Week 0, Week 4, and Week 8
Maintenance SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter.
 SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.

Other: _____

Anaphylaxis Kit

Does this patient require an anaphylaxis kit?
 Yes, with 1st dose Yes, with all doses No
Dosage: • Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
• Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
• 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.
Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Medication Orders

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.
 Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

No labs ordered at this time.
 Other: _____

Skilled nurse to assess and administer and/or teach SUBQ self-administration where appropriate Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____ Phone: _____ Fax: _____
Address: _____ NPI: _____
City, State: _____ Zip: _____ Office Contact: _____

Fax completed form, insurance information, and clinical documentation to:

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