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: _____ ☐ Last chest x-ray – date: _____ ☐ Quantiferon or T Spot Assay result and date: _____	☐ Active TB ☐ Unknown ☐ 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:

