

<b>TREMFYA® (GUSELKUMAB) PRESCRIBER ORDER FORM</b>					
Patient Name:				Date of Birth:	
Address:					
Phone:		Height:		<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:
<b>Clinical Information</b>					
Primary Diagnosis Description:				ICD-10 Code:	
TB Status:	<input type="checkbox"/> PPD (negative) – date: _____ <input type="checkbox"/> Last chest x-ray – date: _____ <input type="checkbox"/> Quantiferon or T Spot Assay result and date: _____			<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown <input type="checkbox"/> Past positive TB infection, course taken: _____	
<b>TREMFYA® (guselkumab) Prescription</b>					
TREMFYA® (guselkumab) refill as directed x 1 year					
<b>Ulcerative Colitis</b>					
Induction	<input type="checkbox"/> IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8				
Maintenance	<input type="checkbox"/> SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter. <input type="checkbox"/> SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.				
<b>Crohn's Disease</b>					
Induction	<input type="checkbox"/> IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8 <input type="checkbox"/> SubQ: Inject 400mg at Week 0, Week 4, and Week 8				
Maintenance	<input type="checkbox"/> SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter. <input type="checkbox"/> SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.				
Other: _____					
<b>Anaphylaxis Kit</b> Does this patient require an anaphylaxis kit? <input type="checkbox"/> Yes, with 1 <sup>st</sup> dose <input type="checkbox"/> Yes, with all doses <input type="checkbox"/> 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.					
<b>Medication Orders</b> <input type="checkbox"/> Other: _____					
<b>IV Flush Orders</b> <input type="checkbox"/> <u>Peripheral</u> : NS 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port</u> : 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.					
<b>Lab Orders</b> <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
Prescriber Signature: _____				Date: _____	
<b>Prescriber Information</b>					
Prescriber Name:			Phone:		Fax:
Address:				NPI:	
City, State:		Zip:		Office Contact:	
Fax completed form, insurance information, and clinical documentation to:					
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