TREMFYA® (GUSELKUMAB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	Height: ☐ inches ☐ cm	Weight: ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

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 and Crohn's Disease

Induction Dose:
☐ 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 (NDC 57894-0651-04 preferred, but not required)

Maintenance Dose:
☐ 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: _____

Plaque Psoriasis and Psoriatic Arthritis

Recommended Dose: ☐ SUBQ: Inject 100mg at Week 0, Week 4, and every 8 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 administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.
Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

