

TREMFYA® (GUSELKUMAB) PRESCRIBER ORDER FORM					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:		Height:		<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:
<input type="checkbox"/> lbs <input type="checkbox"/> kg					
Clinical Information					
Primary Diagnosis Description:				ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA OR (List):					
TB Status:	<div style="display: flex; justify-content: space-between;"> <div> <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: _____ </div> <div> <input type="checkbox"/> Active TB <input type="checkbox"/> Unknown <input type="checkbox"/> Past positive TB infection, course taken: _____ </div> </div>				
TREMFYA® (guselkumab) Prescription					
TREMFYA® (guselkumab) refill as directed x 1 year					
<u>Ulcerative Colitis and Crohn's Disease</u>					
Induction Dose: <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 (NDC 57894-0651-04 preferred, but not required)					
Maintenance Dose: <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: _____					
<u>Plaque Psoriasis and Psoriatic Arthritis</u>					
Recommended Dose: <input type="checkbox"/> SUBQ: Inject 100mg at Week 0, Week 4, and every 8 weeks thereafter					
Other: _____					
Anaphylaxis Kit					
Does this patient require an anaphylaxis kit?					
<input type="checkbox"/> Yes, with 1 st 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.					
Medication Orders					
<input type="checkbox"/> Other: _____					
IV Flush Orders					
<ul style="list-style-type: none"> • <u>Peripheral:</u> NS 2 to 3 mL pre-/post-use. • <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. 					
Lab Orders					
<input type="checkbox"/> No labs ordered at this time.					
<input type="checkbox"/> 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>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: _____	
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					
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