



option care health®

Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,  
Option Care Health

# 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: \_\_\_\_\_  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 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 1<sup>st</sup> 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: \_\_\_\_\_

\_\_\_\_\_

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