VOA Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

TREMFYA (Guselkumab) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ **NEW PATIENT OR**
CHANGE ORDER: ◯ **Drug Change** ◯ **Dose Change** ◯ **Interval Change**

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

CLINICAL INFORMATION

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose? ☐ Yes
No – date of next dose due: _____

Treatments – Tried and Failed:

TB Status:
☐ PPD (negative) – date:
☐ Last chest X-ray – date:
☐ Quantiferon or T Spot Assay result / date: _____
☐ Past positive TB infection, course taken: _____
☐ Active TB

Hepatitis Status:
☐ Complete HepBsAg and anti-HBc, anti-HBs antibodies
☐ Complete Anti-HCV antibody

TREMFYA (Guselkumab) PRESCRIPTION

TREMFYA refill as directed x 1 year.

Induction Dose: ☐ Infuse 200mg IV over at least 1 hour Weeks 0, 4, and 8.

Maintenance Dose: ☐ Inject 100mg every 8 weeks starting week 16.
OR
☐ Inject 200mg SC every 4 weeks if needed for symptom control starting week 12.

ANCILLARY ORDERS

Pre - Medication Orders

☐ Acetaminophen 650mg PO 30 minutes before infusion.
☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion.
☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
☐ Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

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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