

Tremfya (guselkumab) | Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- History & physical
- Supporting clinical documentation
- Any tried/failed therapies
- Tuberculosis (TB) & HBV screening (as indicated)
- Labs (UC & CD): Baseline LFTs/bilirubin

2. Patient Information

☐ Male ☐ Female Height: _____ ☐ in/☐ cm Weight: _____ ☐ lbs/☐ kg ☐ NKDA Allergies

Line type (if applicable): ☐ PIV ☐ PICC ☐ Port ☐ Other:

3. Diagnosis and Clinical Information ICD-10 (required):

☐ Crohn's disease ☐ Ulcerative colitis ☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Other:

4. Prescription Information: Tremfya (IV: 200 mg/20 mL vial; SubQ: 100 mg/mL or 200 mg/2 mL pre-filled syringe, pen, or injector)

Indication	Dosing
Crohn's Disease, Ulcerative Colitis	Step 1: Induction (choose one): <input type="checkbox"/> IV: Infuse 200 mg IV over at least 1 hour at week 0, week 4, and week 8 <input type="checkbox"/> SubQ (option for Crohn's only): Inject 400 mg SubQ at week 0, week 4 and week 8 Step 2: Maintenance (choose one): <input type="checkbox"/> 100 mg subcutaneously at week 16, and every 8 weeks thereafter <input type="checkbox"/> 200 mg subcutaneously at week 12, and every 4 weeks thereafter
Psoriatic Arthritis, Plaque Psoriasis	<input type="checkbox"/> Inject 100 mg subcutaneously at week 0, week 4, and every 8 weeks thereafter
Quantity / Refills	Dispense 1 month supply / QS on all medications. Dispense medical supplies for administration Refill x 12 months OR other:

5. Additional Orders

- For SQ injections: Provide skilled nursing to teach injection technique if needed
- For IV infusion (if ordered): RN to start peripheral IV or use existing CVC. Catheter flushing per Coastal infusion Services Policy & Procedure. Prepare infusion using compatible IV solution for dilution. Infuse over ≥1 hour via 0.2 micron in-line filter. Monitor at least 30 minutes.
- **Premedication:** Give 30 min prior to IV infusion (*Note: if nothing is checked, no premedications will be given*)
 - ☐ Diphenhydramine 25-50mg PO. Patient may decline.
 - ☐ Acetaminophen 325-650mg PO. Patient may decline.
 - ☐ Methylprednisolone 40mg (OR _____ mg) slow IV push (or an equivalent corticosteroid, substitution if needed)

☐ Other orders:

- RN to monitor patient post-infusion per Coastal infusion Services Policy & Procedure and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders: For first doses, standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional/other orders:

Note: If epinephrine auto-injector is required, prescriber to send prescription to retail pharmacy of patient's choice

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License #: _____ DEA #: _____ NPI: _____

Physician Signature (Substitution Permitted)

Date

Physician Signature (Dispense as Written)

Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal infusion Services has my permission to contact the patient's healthplan to obtain any authorizations necessary to enable it to receive payment for services.

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