coastal infusion services
a promptcare company

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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): ☐ IV: Infuse 200 mg IV over at least 1 hour at week 0, week 4, and week 8 ☐ SubQ: Inject 400 mg SubQ at week 0, week 4 and week 8 **Step 2: Maintenance** (choose one): ☐ 100 mg subcutaneously at week 16, and every 8 weeks thereafter ☐ 200 mg subcutaneously at week 12, and every 4 weeks thereafter
Psoriatic Arthritis, Plaque Psoriasis	☐ 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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