

**TREMFYA (GUSELKUMAB) PRESCRIBER ORDER FORM**

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

<input type="checkbox"/> NEW PATIENT OR	<input type="radio"/> Drug Change	<input type="radio"/> Dose Change	<input type="radio"/> Interval Change
Patient Name:	Date of Birth:		
Phone:	Gender:		
Address:			
Allergies:			
Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg		
<b>CLINICAL INFORMATION</b>			
Primary Diagnosis Description:		ICD-10 Code:	
Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No – date of next dose due: _____			
Treatments – Tried and Failed:			

<b>TB Status:</b>	<input type="checkbox"/> PPD (negative) – date: _____	<b>Hepatitis Status:</b>	<input type="checkbox"/> Complete HepBsAg and anti-HBc, anti-HBs antibodies
	<input type="checkbox"/> Last chest X-ray – date: _____		<input type="checkbox"/> Complete Anti-HCV antibody
	<input type="checkbox"/> Quantiferon or T Spot Assay result/date: _____		
	<input type="checkbox"/> Past positive TB infection, course taken: _____		
	<input type="checkbox"/> Active TB		
<b>PRESCRIPTION</b>			
TREMFYA refill as directed x 1 year.			
<b>Induction Dose:</b> <input type="checkbox"/> Infuse 200mg IV over at least 1 hour, Weeks 0, 4, and 8			
<b>Maintenance Dose:</b> <input type="checkbox"/> Inject 100mg every 8 weeks starting week 16 <b>OR</b>			
<input type="checkbox"/> Inject 200mg SC every 4 weeks, if needed, for symptom control starting week 12			

<b>ANCILLARY ORDERS</b>			
<b>Pre-Medication Orders</b>			
<input type="checkbox"/> Acetaminophen 650mg PO 30 minutes before infusion. <input type="checkbox"/> Diphenhydramine 25mg PO/IV 30 minutes before infusion. <input type="checkbox"/> Methylprednisolone Succinate 125mg IV push 20 minutes before infusion. <input type="checkbox"/> Other: _____			
<b>PRN Hypersensitivity Meds:</b>			
<ul style="list-style-type: none"> <li>• Epinephrine 0.3mg</li> <li>• Solu-Cortef 100mg</li> <li>• Solu-Medrol 125mg</li> <li>• Diphenhydramine 25-50mg</li> <li>• NS 500 ML (&gt;30kg)</li> </ul>			

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature:	Date:	
<b>PRESCRIBER INFORMATION</b>		
Prescriber Name:	Phone:	Fax:
Address:		NPI:
City, State, Zip:		Office Contact:
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