

# Tremfya® (guselkumab) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

**Fax completed form, insurance information and clinical documentation to 414-260-7368.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Height: \_\_\_\_\_  inches  cm Weight: \_\_\_\_\_  lbs  kg

## Clinical Information

Primary Diagnosis Description: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**TB Status**  PPD (negative) – date: \_\_\_\_\_  Active TB  Unknown  
 Last chest x-ray – date: \_\_\_\_\_  Other \_\_\_\_\_  
 Past positive TB infection, course taken: \_\_\_\_\_

## Tremfya® (guselkumab) Prescription

**Tremfya® (guselkumab) refill as directed x 1 year Crohn's Disease or Ulcerative Colitis**

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

## Ancillary Orders

### Anaphylaxis Kit

Treat per Froedtert Home and Specialty Infusion protocol.

### Pre-Medication Orders

Other: \_\_\_\_\_

**IV Access and Flush Orders:** RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.  
 Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

### Lab Orders

No labs ordered at this time.  
 Other: \_\_\_\_\_

***Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SQ) access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.***

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

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ NPI \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Office Contact \_\_\_\_\_



Original - Medical Records

**Froedtert Home and Specialty Infusion**  
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