

Guselkumab (Tremfya) Injection Order Form

Patient Name: _____

Date of Birth: _____

Patient Phone #: _____

Date: _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart

Last Dose: _____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____

J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

☐ Labs to be reviewed or ordered by infusion center☒ Baseline☒ CMP☒ CBC with Differential☒ TB screening (QuantiFERON or alternative) - prior to initiation☒ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)☐ HIV (Antibody, Antigen)☒ Maintenance (every _____)☒ CBC with Differential☒ CMP☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)☐ Other: _____

Provider Information

Live vaccines should not be given concurrently.

Nursing Order

☒ Do not administer Guselkumab with an active infection, including clinically important localized infection, or if the patient is taking antibiotics for current infection.☒ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

☐ Acetaminophen 650 mg PO once☐ Dexamethasone 20 mg IV once☐ Diphenhydramine 25 mg PO once☐ Dexamethasone 20 mg PO once☐ Diphenhydramine 25 mg IV once☐ Methylprednisolone 125 mg IV once☐ Diphenhydramine 50 mg PO once☐ Methylprednisolone 40 mg IV once

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- ☐ Diphenhydramine 50 mg IV once ☐ Other: _____
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once

Medication Orders

Induction Dose

- ☐ Guselkumab 200 mg IV over 60 minutes at Week 0, Week 4, and Week 8

Maintenance Dose

- ☐ Guselkumab 100 mg SQ at Week 16, then every 8 weeks thereafter
- ☐ Guselkumab 200 mg SQ at Week 12, then every 4 weeks thereafter

Refills:

(Refills for one year from date of signature unless indicated)

- ☐ Zero ☐ For 12 months ☐ _____

Pharmacy may substitute a biosimilar based on insurance coverage.

Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Monitor patients for 30 minutes after the first infusion. Monitoring not needed for subsequent infusions unless a reaction has occurred. Infuse medication over 60 minutes.

Emergency / Hypersensitivity Orders

- ☒ Notify provider for next steps once patient stabilized
- ☒ Follow standard orders for management of allergies and anaphylaxis reactions
- ☒ In absence of standard protocol, follow the orders below:
- ☒ Nursing to stop infusion, maintain airway, place supine, elevate legs, O₂ 2 L NC
 - ☒ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
 - ☒ Diphenhydramine 25 mg IV q6h PRN itching/hives
 - ☒ Hydrocortisone 100 mg IV Once PRN hypersensitivity
 - ☒ Methylprednisolone 125 mg IV Once PRN hypersensitivity
 - ☒ Famotidine 20 mg IV Once PRN hives/itching
 - ☒ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
 - ☒ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated