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| ADULT AMBULATORY INFUSION ORDER **Guselkumab (Tremfya)**  |   **NAME:** **BIRTHDATE:** *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.**  |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Patient Information

Provider Information

\***Please fax a copy of the following** □Demographics □ Insurance Information □ Current Lab Results **patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

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

 Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TB Test Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ □ Copy Attached

Hep B Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ □ Copy Attached

Pre-medications:

Diphenhydramine: □ PO □ IV □ 25 mg □ 50mg

Acetaminophen: □ PO □ 650 mg □ 1000 mg

Solu-Medrol: □ IV □ \_\_\_\_\_ mg

Other OTC: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Pre-Medications

Wait Time after Pre Medications:

 □ 20 minutes □ 30 minutes □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No wait time

MC2893 (04/25)

Labs:

□ CBC w/diff □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ CRP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ ESR □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_□ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

 **Please check preferred product:**

**Tremfya:**

* **Induction Dose: Infuse 200 mg IV at Weeks 0, 4, and 8.**
* **Maintenance Dose:** [ ]  **100 mg subcutaneous injection** [ ]  **200 mg subcutaneous injection**

**Frequency:** [ ]  **Week 16, and every 8 weeks** [ ]  **Week 12, and every 4 weeks**

* New Start Therapy [ ]  Continuation of Therapy Date of Last Dose: \_\_\_\_ /\_\_\_ /\_\_\_\_