Tremfya (Guselkumab) Referral Form

REQUIRED INFORMATION

☐ Provider signature (see below)
☐ Patient demographics/insurance information
☐ Clinical/Progress Notes, Labs (including TB Test and baseline LFTs), and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:

☐ **Plaque Psoriasis (ICD-10 _____)** ☐ **Psoriatic Arthritis (ICD-10 _____)**

Dose: ☐ Tremfya 100 mg subcutaneously at weeks 0 and 4, then every 8 weeks thereafter

Refill: ☐ PRN x 1 year OR _____ times

Diagnosis:

☐ **Crohn's Disease (ICD-10 _____)** ☐ **Ulcerative Colitis (ICD-10 _____)** ☐ **Other (ICD-10 _____)**

Induction Dose: ☐ Tremfya 200 mg in 250 mL NS IV to be infused over 1 hour at week 0, 4, and 8

Maintenance Dose: ☐ Tremfya 100 mg subcutaneously every 8 weeks beginning at week 16

☐ Tremfya 200 mg subcutaneously every 4 weeks beginning at week 12

Refill: ☐ PRN x 1 year OR _____ times

Pre-Medication Orders (optional):

☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO

☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO

☐ Other: _____

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

TB screening and LFTs should be monitored at regular intervals while on therapy

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

☐ May use Burnham's Vital Care flush and catheter maintenance protocol

Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care

☐ May use Burnham's Vital Care anaphylaxis protocol

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:

Practitioner Address: