Oregon Health & Science University Hospital and Clinics Provider's Orders PO9031 ADULT AMBULATORY INFUSION ORDER **Guselkumab (TREMFYA) Injection** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
3. Guselkumab may increase the risk of infections, particularly upper respiratory tract infections, gastroenteritis, tinea infections, and herpes simplex infections. Consider the risks versus benefits prior to treatment initiation in patients with a history of chronic or recurrent infection. Treatment must not be initiated in patients with clinically important active infections until it is resolved or treated. Monitor for signs and symptoms of infection. Patients must be brought up to date with all immunizations before initiating therapy. Live vaccines must not be given concurrently.
4. For plaque psoriasis & psoriatic arthritis: guselkumab 100 mg is administered subcutaneously at weeks 0, 4, and then every 8 weeks thereafter.
5. For ulcerative colitis: guselkumab 200 mg is administered intravenously on weeks 0, 4, and 8. Maintenance doses are then administered subcutaneously starting at week 12-16 depending on dosing strategy prescribed. Use lowest effective dosage to maintain therapeutic response.
6. Guselkumab subcutaneous injections are included on the Center for Medicare & Medicaid Services Self-Administration Drug Exclusion List. An outpatient prescription for subcutaneous maintenance dosing will need to be supplied by the provider for patients with traditional Medicare (Medicare A/Medicare B) for self-administration.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. TREATMENT PARAMETER – Hold treatment and contact provider if patient has signs or symptoms of infection.
3. Prior to guselkumab subcutaneous administration, remove prefilled syringe from the refrigerator and allow to warm at room temperature for 30 minutes in original carton. Do not warm in any other way
4. Monitor for signs and symptoms of infection. Advise patient to report symptoms of infection.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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MEDICATIONS:

☐ **Ulcerative Colitis/Crohn's Disease**

- ☐ **Induction:** guselkumab (TREMFYA) 200 mg in 250 mL of 0.9% sodium chloride, IV, over 1 hour, ONCE, on weeks 0, 4, and 8

  Maintenance *(must check only one)*
  - ☐ guselkumab (TREMFYA) injection 100 mg, subcutaneously, ONCE, every 8 weeks thereafter starting on week 16
  - ☐ guselkumab (TREMFYA) injection 200 mg, subcutaneously, ONCE, every 4 weeks thereafter starting on week 12

☐ **Plaque Psoriasis/Arthritis**

- ☐ **Induction**: guselkumab (TREMFYA) injection 100 mg, subcutaneously, ONCE, on weeks 0 and week 4
- ☐ **Maintenance**: guselkumab (TREMFYA) injection 100 mg, subcutaneously, ONCE, every 8 weeks thereafter

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

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Printed Name:_____ **Phone:** _____ **Fax**:_____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**