

(Guselkumab)



Tremfya infusion orders

Patient Name _____

DOB _____

Phone Number _____

M ____ F ____

DIAGNOSIS *Please provide ICD-10 code*

_____ Psoriatic Arthritis

_____ Plaque Psoriasis

PRE-MEDICATIONS

Acetaminophen 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

_____ (other)

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

_____ (other)

Tremfya (Guselkumab) ORDERS

DOSAGE & FREQUENCY

100mg SQ at weeks 0, 4, and then every 8 weeks thereafter

Patient Weight

_____ lbs

_____ kg

NOTES:

ORDERING PROVIDER

Signature _____ Phone _____ Fax _____

Provider _____ Date _____