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.
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.

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

- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. Prior to guselkumab 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.
3. Administer subcutaneously into front of thighs, lower abdomen (except for 2 inches around navel) or back of upper arms. Do not inject into areas where the skin is tender, bruised, red, hard, thick, scaly, or affected by psoriasis.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

- guselkumab (TREMFYA) injection 100 mg, subcutaneous, ONCE

Interval: *(must check at least one)*

- **Initiation**: week 0 ___________ and week 4 ___________.
- **Maintenance**: every 8 weeks thereafter
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: ___________________________
Printed Name: ___________________________ Phone: __________ Fax: __________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

☐ Beaverton
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

☐ NW Portland
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

☐ Gresham
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

☐ Tualatin
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders