

McLeod Health

Guselkumab (Tremfya) Treatment Plan for Gastroenterology

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

K50.0 _____ Crohn's Disease (small intestine)

K50.1 _____ Crohn's Disease (large intestine)

K50.8 _____ Crohn's Disease (small and large intestine)

Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

Acetaminophen 650 mg PO

Diphenhydramine: Dose: 25 mg 50 mg Route: PO or IVP

Methylprednisolone: Dose: 40 mg or 125 Route: IVP

Famotidine: Dose: 20 mg Route: PO or IVPB

Other (include drug, dose, and route): _____

Drug Orders:

- Guselkumab (Tremfya) (J1628) 200 mg per 250 mL Sodium Chloride 0.9% IV to infuse over 1 hour via filtered tubing

Frequency: Weeks 0, 4, and 8

Other: _____

- Subcutaneous maintenance dosing to be initiated by physician office starting at Week 12 every 4 weeks thereafter

Lab Orders:

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

- Appropriate access and line care orders per health system policy

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received guselkumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____
and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

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|--|---|--|
| <input type="checkbox"/> McLeod Regional Medical Center (Florence) | <input type="checkbox"/> McLeod Health Loris | <input type="checkbox"/> McLeod Health Cheraw |
| <input type="checkbox"/> McLeod Health Seacoast (Little River) | <input type="checkbox"/> McLeod Health Dillon | <input type="checkbox"/> McLeod Health Clarendon (Manning) |

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.