

MHS Home/Alternate Site Infusion Services Guselkumab (Tremfya) Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name: _____	DOB: ____/____/____	Weight: _____ lb/kg
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Patient Phone Number: (____) ____-____	Requested Date of Service: ____/____/____
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Patient Allergies: _____

Diagnosis: _____ **ICD – 10 Code:** _____

Baseline Labs required:

- | | | |
|---------------------|----------------------|---------------|
| • CBC/CMP | Date: ____/____/____ | Result: _____ |
| • Latent TB testing | Date: ____/____/____ | Result: _____ |
| • HBV screening | Date: ____/____/____ | Result: _____ |
| • HCV screening | Date: ____/____/____ | Result: _____ |
| • HIV screening | Date: ____/____/____ | Result: _____ |

Maintenance Labs required:

- CBC/CMP every 12 months
- Latent TB testing every 12 months

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs.

Provider Order for Guselkumab (Tremfya) Injection

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pre-Medication(s): none required

Biologic Injection:

- Guselkumab (Tremfya) Dosing:
- 100 mg SUBQ at week 0, week 4, then every 8 weeks
 - 100 mg SUBQ every 8 weeks

Skilled Nurse to draw labs as follows:

- | | |
|--|---------------------------|
| <input type="checkbox"/> CBC w/ diff every 12 months | Or other frequency: _____ |
| <input type="checkbox"/> Latent TB testing every 12 months | Or other frequency: _____ |

Skilled Nurse Interventions:

- Admit (first visit) patient to services for home infusion therapy of Guselkumab (Tremfya).
- Complete Skilled Nurse visit with each injection for ongoing home infusion therapy of Guselkumab (Tremfya).
- Obtain vital signs (TPR & B/P) at baseline and post-injection.
- Obtain patient weight at each visit.
- Draw labs as ordered.
- Inject Guselkumab (Tremfya) as prescribed.
- If vital signs are stable after injection, Skilled Nurse will complete visit.

CONTINUED ON NEXT PAGE

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):

The Skilled Nurse will:

- Administer emergency medications as prescribed (below).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number _____ **(required)** for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO₂>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:

Address: _____

Phone #: _____ Fax#: _____

Return completed orders to:

MultiCare Home/Alternate Infusion Services
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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