

TREMFYA (GUSELKUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____
 Allergies: _____

DIAGNOSIS (Provider must specify)

Ulcerative Colitis, ICD 10: K51: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION (IV INDUCTION DOSE)

MEDICATION	DOSE	ROUTE	FREQUENCY
Tremfya	<input type="checkbox"/> 200 mg	<input type="checkbox"/> IV	<input type="checkbox"/> Week 0, 4, 8

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tremfya	<input type="checkbox"/> 100 mg	<input type="checkbox"/> subcutaneous inj.	<input type="checkbox"/> Week 16, & every 8 wks
	Or <input type="checkbox"/> 200 mg		<input type="checkbox"/> Week 12, & every 4 wks

x3 IV infusion needs to be completed prior to self-administered SubQ injections.

Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621 MD: 240.224.8607 ME: 207.407.7272 NH: 603.217.5371
 NJ: 201.581.4521 VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____