Local Infusion

MYLOCALINFUSION.COM

# 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

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Tremfya | ❑ 100 mg | ❑ subcutaneous inj. | ❑ Week 16, and every 8 weeks thereafter |
| | Or ❑ 200 mg | ❑ subcutaneous inj. | ❑ Week 12, and every 4 weeks thereafter |

x3 IV infusion needs to be completed prior to 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: _____