Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

TREMFYA (guselkumab) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB: SEX: M ☐ F ☐
☐NKDA Allergies:		Weight lbs/kg:

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:	
Address:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

DOSAGE AND ADMINISTRATION:

☐ ***Ulcerative Colitis:***
Induction: 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, and Week 8.

Dx Code: _____

☐ ***Crohn's Disease:***
Induction: 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, and Week 8.

Dx Code: _____

☐ Other:_____

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000 MG ☐other _____
☐ Solumedrol 125mg IV ☐other _____
☐ Benadryl ☐25mg ☐50mg ☐other _____ ☐IV ☐PO
☐ Medication _____ Dose _____Route _____
☐ _____ *(other)* ☐ _____ *(other)*

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Recent labs to **include QuantiFERON**, and if have CBC, CMP and Hep B surface antigen please send or any other recent labs
_____ Current Medication List
_____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____ **NPI**_____

Provider _____ Phone _____ Fax _____