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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 _____