

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 _____