RESTORE HEALTH
INFUSION AND WELLNESS

TREMFYA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ K50.____ (Crohn's Disease) ☐ K51.____ (Ulcerative Colitis)

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No **CMP/LFTs Completed:** ☐ Yes ☐ No **TB Test:** ☐ Positive ☐ Negative

TREATMENT

TREMFYA (guselkumab)

Route: Intravenous infusion

Dose: ☐ 200mg

Frequency:

☐ Induction: Once on weeks 0, 4, and 8

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Quantity: _____ **Refills:** ____

Provider Signature: _____ Date: _____