

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: _____

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