Local Infusion

MYLOCALINFUSION.COM

TREMFYA (GUSELKUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments:_____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Ulcerative Colitis, ICD 10: K51:_____
❑ Moderately to severely active Crohn's disease, ICD 10 K 50._____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:
❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION (IV INDUCTION DOSE)

MEDICATION	DOSE	ROUTE	FREQUENCY
Tremfya	❑ 200 mg	IV	Week 0, 4, 8

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Tremfya	❑ 100 mg	subcutaneous inj.	❑ Week 16, & every 8 wks
	Or ❑ 200 mg		❑ Week 12, & every 4 wks

x3 IV infusion needs to be completed prior to self-administered SubQ injections.
❑ Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS