

INFUSION & MEDICAL CENTER

1.Patient Name	DOB	Patient Phone/Cell #
Patient demographic and insurance inform		
2.Medical Information (Please select primary o	diagnosis and comp	
Primary Diagnosis: Crohn's Disease (CD)		ICD-10 Code: K50:
Ulcerative Colitis (UC)		ICD-10 Code: K51:
Other		
Allergies:		(or attach list
3.Clinical Information — Please fax with Infusi	on Order Form:	
 Clinical documentation supporting primary diagnosis 		
 Recent Lab/Test Results including: 		Patient
o Tuberculosis (TB) screening results		Weight: lbs.
o Liver Enzymes and bilirubin levels		Height:in.
Medication List		
 Previous Drug Therapy History, including therapies trai 	led and/or failed and da	ate of last infusion:
TREMFYA® 4. Drug Order: Induction (IV) Dosing for Crohn's or Ulcerative Colitis d	(guselkumab)	J Code: J1628
Administer 200 mg intravenously over at least one	hour at weeks 0, 4, and	8.
	Do	oses Authorized: 3 (three)
Subcutaneous maintenance doses must be sent to page	tient's/insurance prefe	rred specialty pharmacy
Pre-Medication Orders:		
No Pre-medications are recommen	nded based on manufac	turer guidelines.
Adverse Drug Reaction Protocol: Manage any adverse By signing this form and utilizing our services, I am authorizing medical and pharma	•	· · · · · · · · · · · · · · · · · · ·
5.Physician Signature:	//	Date:
Dispense as written	Substitution permitted	
Printed Physician's Name with Credentials:	Phone #:	
FAX ALL INFORMATION	CENTRAL INTAKE PHONE	
CENTRAL FAX 803.999.1754		3.999.1750
CENTRAL FAX OUD. 399.17 JT	003.333.1730	