

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):**

Primary Diagnosis: \_\_\_\_\_ Crohn's Disease (CD) ICD-10 Code: K50: \_\_\_\_\_  
 \_\_\_\_\_ Ulcerative Colitis (UC) ICD-10 Code: K51: \_\_\_\_\_  
 \_\_\_\_\_ Psoriasis or Active Psoriatic Arthritis ICD-10 Code: L40: \_\_\_\_\_  
 \_\_\_\_\_ Other \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information — Please fax with Infusion Order Form:**

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Tuberculosis (TB) screening results
  - o Liver Enzymes and bilirubin levels
- Medication List

<b>Patient</b>
<b>Weight:</b> _____ lbs.
<b>Height:</b> _____ in.

**4. Drug Order:** **TREMFYA® (guselkumab)** J Code: J1628

**Crohn's or Ulcerative Colitis diagnosis:**

**Induction Dose: \*3 (three) doses authorized**

- IV:** Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8
- SUBQ:** Inject 400mg at Week 0, Week 4, and Week 8

**Maintenance Dose: \*Refill as directed x 1 year**

- SUBQ:** Inject 100mg starting at week 16, and every 8 weeks thereafter
- SUBQ:** Inject 200mg starting at week 12, and every 4 weeks thereafter

**Plaque Psoriasis and Psoriatic Arthritis: \*Refill as directed x 1 year**

**Induction Dose:**  **SUBQ:** Inject 100mg at Week 0, Week 4, and every 8 weeks thereafter

**Maintenance Dose:**  **SUBQ:** Inject 100mg every 8 weeks

**Other:** \_\_\_\_\_

**Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.**

**Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.**

Anaphylaxis Kit:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ **Date:** \_\_\_\_\_

Dispense as written

Substitution permitted

Printed Physician's Name with Credentials: \_\_\_\_\_ Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>CENTRAL INTAKE PHONE</b> <b>803.999.1750</b>	 Access Intramed Plus prescription order forms here.
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