# TREMFYA IV
(guselkumab)

FLEXCARE INFUSION CENTERS

## PATIENT DEMOGRAPHICS

| | |
|---|---|
| Patient Name: | Patient's Phone Number: |
| Date of Birth: | Address: |
| Allergies: See List ☐ NKDA ☐ | City, State, Zip: |
| Weight:_____lbs or _____kg | Patient's Email: |

## REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Liver Enzymes and Bilirubin Levels

## PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.019 Crohn's disease of small intestine with unspecified comps
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.119 Crohn's disease of large intestine with unspecified comps
☐ K50.80 Crohn's disease of both small and large int without complications
☐ K50.819 Crohn's disease of both small and large int w/unsp comp
☐ K50.90 Crohn's disease, without complication
☐ K50.919 Crohn's disease, unspecified, with unspecified comps
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other:_____

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Tremfya.
☐ Provider Prescribed: _____

## PRIMARY MEDICATION ORDER

**Induction** (to be administered in infusion clinic):
☐ Tremfya 200mg IV at Weeks 0, 4, and 8
☐ Other:_____

**Maintenance** (to be self-administered by patient):
☐ Tremfya 100mg subQ at Week 16 and every 8 weeks thereafter
☐ Tremfya 200mg subQ at Week 12, and every 4 weeks thereafter
☐ Other:_____

☐ Infusion Clinic will coordinate initial maintenance dose from Specialty Pharmacy
☐ Provider's Office will coordinate maintenance dose from Specialty Pharmacy
First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

| | |
|---|---|
| Provider Name: | Office Contact: |
| Address: | Phone: |
| City, State, Zip: | ☐ Fax: |
| NPI **AND** License: | ☐ Email: |

_____ _____
Provider Signature Date

**FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals**

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