medix infusion

Tremfya® Order Form
(guselkumab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

Diagnosis and Clinical Information

ICD 10 Code Required

☐ Ulcerative Colitis (K51.00-K51.919) ICD10 _____

Prescription

DIRECTIONS/DURATION

IV LOADING DOSE: 200mg IV at Week 0, 4, and 8

Is patient currently receiving therapy above from another facility? If yes, Facility Name: _____

☐ YES ☐ NO Date of last treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Medix Infusion ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
☐ ESR q _____ ☐ LFTs q _____ ☐ Other _____

Required Medical Documentation

☐ TB Screening (within 12 months of start of therapy and annually to continue treatment)
☐ Include signed and completed order (MD|prescriber to complete)
☐ Include patient demographic information and insurance information
☐ Include patient's medication list
☐ Supporting clinical notes to include any past tried and|or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  ☐ Has the patient had a documented contraindication|intolerance or failed trial of a corticosteroid or immunomodulator?
    ☐ YES ☐ NO If yes, which drug(s)? _____
☐ Does the patient had a documented contraindication|intolerance or failed trial any bilogic (i.e.Humira, Stelara, Cimzia, Iinfliximab)?
  ☐ YES ☐ NO If yes, which drug(s)? _____
☐ Include labs and|or test results to support diagnosis
☐ If applicable - Last known biological therapy: _____ and last date received: _____ If patient is switching biologic therapies, please perform a wash-out period _____ weeks prior to starting Tremfya®.
☐ Other medical necessity: _____

Prescriber Information

Prescriber Name: _____ Signature: _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____