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

ICD 10 Code Required

☐ Crohn's Disease K.50. _____

☐ Ulcerative Colitis K51. _____

Medication Order

DIRECTIONS/DURATION

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

CROHN'S IV LOADING DOSE: 200mg IV over at least 1 hour at Week 0, 4, and 8

Is patient currently receiving therapy above from another facility?

☐ YES ☐ NO

If yes, Facility Name: _____

Date of last treatment: _____

PRE-MEDICATION ORDERS

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone _____mg IVP

☐ Other: _____

Lab Orders

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Required Clinical 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: _____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____