Tremfya®Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX
Specialty Infusion Services
In Partnership with Major Health Systems

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ○ N ○ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____Crohn's Disease
_____Ulcerative Colitis
_____Other: _____

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

☐ No labs ordered at this time
☐ Other: _____

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:

○ **Remicade** ○ **Orencia** ○ **Humira** ○ **Cimzia** **Date:** _____

2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **Tremfya® (guselkumab)**

☐

Ulcerative Colitis	
Induction	☐ IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8
Maintenance	☐ SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter. ☐ SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.

☐

Crohn's Disease	
Induction	☐ 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	☐ SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter. ☐ SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.

Other: _____

Pre-Medication Orders:

☐ Acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO ☐ Cetirizine (Zyrtec) 10mg PO
☐ Loratadine (Claritin) 10mg PO ☐ Diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV ☐ Hydrocortisone (Solu-Cortef) 100mg IV
☐ Other: _____ Dose: _____ Route: _____

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

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

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

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date