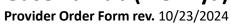
Guselkumab (Tremfya)





PATIENT INFORMATION	Referral Status: □ New Referral □ Updated Order □ Order Renewal
Patient Name:	DOB: Patient Phone:
Patient Address:	Patient Email:
Allergies:	☐ NKDA Weight (lbs/kg): Height (in/cm):
Sex: ☐ M / ☐ F Date of Last Infusion:	Next Due Date: Preferred Location:
DIAGNOSIS (Please provide ICD-10 code in Ulcerative Colitis:	space provided)
Other: Description:	·
THERAPY ADMINISTRATION & DOSIN ☐ Tremfya 200mg IV in 250ml NS over 1 hour ☐ Only IV induction dosing will be provided. (So WILL NOT BE provided). FREQUENCY ☐ Induction: week 0, week 4, and week 8 ADDITIONAL ORDERS	IG LABORATORY ORDERS ☐ CBC with diff
PROVIDER INFORMATION Preferred Contact Name: Ordering Provider: Referring Practice Name: Practice Address:	Preferred Contact Email: Provider NPI: Phone: Fax: City: State: Zip Code:
Tractice Address.	City. State. Zip Code.
Required Documentation: Patient demos, co	LIST (Additional documentation required for processing and insurance approval) py of front and back of primary and secondary insurance, 2 most recent OVN including mmunosuppressants, biologic agent and steroids, Colonoscopy Bilirubin,
Provider Name (print)	Provider Signature Date