Tremfya

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
☐ NKDA ☐ Allergies:		Weight lbs/kg:	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change		Last infusion date (if applicable):	

REQUIRED DOCUMENTATION

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

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

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO **Diphenhydramine** (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Cetirizine (Zyrtec) ☐ 10mg PO **Methylprednisolone** (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Loratadine (Claritin) ☐ 10mg PO **Hydrocortisone** (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose:_____ Route:_____ Frequency: _____

MEDICATION ORDER

Tremfya

IV LOADING DOSE ☐ 200mg IV 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: _____

PROVIDER INFORMATION

Provider Name:	Provider Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.