TREMFYA INFUSION ORDER (GUSELKUMAB)

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight (Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ L40.0: Psoriasis vulgaris
- ☐ K51.90: Ulcerative Colitis
- ☐ K50.90: Crohn's Disease
- ☐ Other: _____

TREMFYA THERAPY ORDER

- ☐ Tremfya 200mg IV for week 0, 4 & 8
- ☐ Tremfya 100mg SubQ at week 16 followed by every 8 weeks x 1 Year
- ☐ Tremfya 200mg SubQ at week 12 followed by every 4 weeks x 1 Year

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994