INTRAMED Plus
infusion services

TREMFYA®

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** __________ **Patient Phone/Cell #** ______________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Ulcerative Colitis (UC) ICD-10 Code: K51:____

_____ Other ______________________ ICD-10 Code: ________

Allergies: ______________________ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Tuberculosis (TB) screening results
- Medication List
- Previous Drug Therapy History, including therapies trailed and/or failed and date of last infusion:

____

- Washout period of ____________weeks desired prior to the initiation of this ordered therapy

Patient
Weight: _______ lbs.
Height ________ in.

TREMFYA® (guselkumab) J Code: J1628

4. Drug Order:

Induction:

Administer 200 mg intravenously over at least one hour at weeks 0, 4, and 8.

Doses Authorized: 3 (three)

Pre-Medication Orders: ______________________

No Pre-medications are recommended based on manufacturer guidelines.

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

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

5. Physician Signature: ______________________ / ______________________ Date: ____________

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: ______________________ Phone #: ______________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

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