



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

TREMFYA IV ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

INDICATION:

- K51.90 Ulcerative Colitis
- K50.90 Crohn's Disease
- Other

DRUG:

- 200mg IV at week 0, 4 and 8
Maintenance:
- 100mg SQ week 16 and every 8 weeks thereafter
- 200mg week 12 and every 4 weeks thereafter

PREMEDICATION ORDERS:

- Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
- Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
- Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.
- Other

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B
- Bilirubin
- Other: _____