REVITALIZE
INFUSION CENTER

Tremfya®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Crohn's Disease (CD) ICD-10 Code: K50.___

☐ Ulcerative Colitis (UC) ICD-10 Code: K51.___

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
- Relevant labs and tests including:
  - TB Screening Results
  - Liver Enzymes
  - Bilirubin Levels
- Medication List
- Documentation of previously trailed and failed therapies including details regarding treatment failures, intolerances and or contraindications

Height: _____

Weight: _____

Tremfya® Orders:

☐ Induction IV Dosing: Administer 200 mg intravenously over at least an hour at Weeks 0, 4 and 8 to provide a total of 3 doses

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: ☐ Obtain liver enzymes at baseline and every _____ thereafter

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus