REVITALIZE
INFUSION CENTER

Tremfya®

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.___

☐ Psoriasis or Active Psoriatic Arthritis ICD-10 Code: L40.___

☐ 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
- Active Medication List
- Relevant labs and tests
- Required Information:
  - Tuberculosis (TB) Screening Results
  - Liver Enzymes and bilirubin levels

Height: _____

Weight: _____

Tremfya (guselkumab) Order:

☐ **CD or UC**

☐ **Induction Dose:** Infuse IV 200 mg over 1 hour at Week 0, Week 4 and Week 8 to provide 3 doses

☐ **Maintenance Dose:** Inject SUBQ ☐ 100 mg or ☐ 200 mg on week _____ and then every ____ weeks thereafter for one year

☐ **Psoriasis or Psoriatic Arthritis:**

☐ **Induction Dose:** Inject 100 mg at Week 0, Week 4 and every 8 Weeks thereafter for 1 year

☐ **Maintenance Dose:** Inject 100 mg every 8 weeks for 1 year

☐ **Other:** _____

Pre-Medication Orders:_____

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

Lab Orders:_____

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 #:**

Please fax the completed order form and all other requested information to: 601-714-1569

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

Revitalize Revitalize Locations InfusionPlus