

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



TREMFYA ORDER FORM

Patient Name: _____ ICD-10 Code: _____
 Date of Birth: _____ Allergies: _____
 Weight: _____ lbs OR _____ kg

Therapy Status

New Start
 Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____
 Provider NPI: _____ Provider Address: _____
 Provider Phone: _____

MEDICATION ORDER

Tremfya	Indication: Ulcerative Colitis	Refills for one year from date of signature unless indicated below. _____ Refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Negative TB result and date: _____ ✓ Baseline AST/ALT & Bilirubin
	<input type="checkbox"/> Induction: Infuse 200mg IV at week 0, week 4, and week 8 over a minimum of 60 minutes. <input type="checkbox"/> Maintenance: <input type="checkbox"/> Inject 100mg subcutaneously at week 16 and then every 8 weeks. <input type="checkbox"/> Inject 200mg subcutaneously at week 12 and then every 4 weeks.		
	Indication: Crohn's Disease		
	<input type="checkbox"/> IV Induction: Infuse 200 mg on weeks 0, 4, and 8. <input type="checkbox"/> Induction: Inject subcutaneously 400 mg (as two 200 mg injections) on weeks 0, 4, and 8. <input type="checkbox"/> Maintenance: <input type="checkbox"/> Inject 100mg subcutaneously at week 16 or 200 mg every 4 weeks beginning at week 12.		

PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature _____ Date _____