Tremfya°Infusion Form Fax Referral To: 877-438-9380 Contr Healt	NUUM 1
PREVIOUS ADMINISTRATION	
Please provide the following information: Last Infusion Date: Next Infusion Date:	
Patient Information	
Patient Name: DOB: Sex: O F Height: Weight:	
Phone Number: Email Address:	
Allergies: Is the patient Diabetic: Y O NO ICD-10 Code:	
Emergency Contact: Phone Number:	
Primary Diagnosis: Crohn's Disease Infusion Center - Lab Orders (Check order for Infus Ulcerative Colitis	
Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion: © Remicade © Orencia © Humira © Cimzia Date: 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening	
Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:	
Physician Information	
Prescribing Physician: Practice Name: Practice Phone: Practice Fax:	
Email: Office Contact: Co-managing Physician: Phone/Email:	
Medication Order	
Medication: Tremfya [®] (guselkumab)	
Ulcerative Colitis Induction IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8	
Maintenance SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter.	
□ SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.	
Crohn's Disease	
Induction IV: Infuse 200mg over at least 1 hour at Week 0, Week 4, and Week 8 SubQ: Inject 400mg at Week 0, Week 4, and Week 8	
MaintenanceImage: SubQ: Inject 100mg starting at week 16, and every 8 weeks thereafter.	
□ SubQ: Inject 200mg starting at week 12, and every 4 weeks thereafter.	
Other:	
Pre-Medication Orders:	
□ Acetaminophen (Tylenol) □ 500 mg □ 650 mg □ 1000 mg PO □ Loratadine (Claritin) 10mg PO □ Diphenhydramine (Benadryl) □ 25 mg □ 50 mg □ PC	
□Methylprednisolone (Solu-Medrol) □40mg □125mg IV □Hydrocortisone (Solu-Cortef) 100mg IV	
□Other: Dose: Route:	
Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.	
By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELO By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance provide	
Physician's NPI# Physician's Address	

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.