Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Bronx
226 West 238th Street
Bronx, NY 10463

Brooklyn/Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Long Beach
917 Beech Street
Long Beach, NY 11561

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

NYC Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Office: 212-803-3339 Fax : 646-768-8600

Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Manhattan/FIDI
30 Broad Street
Suite 401
New York, NY, 10004

Manhattan/Midtown
120 East 56 Street
Suit 3D
New York, NY 10022

Manhattan/Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

Manhattan
57W 57Street
Suite 601
New York, NY 10019

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

Holbrook/ Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Woodbury
75 Froehlich Farm
Woodbury, NY 11797

TREMFYA (guselkumab) ORDER FORM

Date: ____________________

PATIENT INFORMATION

Name:	Phone:	DOB: SEX: M ☐ F ☐
☐ NKDA Allergies:		Weight lbs/kg:

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:	
Address:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

TREMFYA: is an interleukin-23 antagonist indicated for the treatment of adult patients with:

- Moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- Active psoriatic arthritis
- Moderately to severely active ulcerative colitis

DOSAGE AND ADMINISTRATION:

Recommended Evaluations and Immunizations Prior to Treatment Initiation

•MEvaluate patients for tuberculosis (TB) infection prior to initiating treatment with TREMFYA

• Complete all age-appropriate vaccinations according to current immunization guidelines [see Warnings and Precautions.

Recommended Dosage

Plaque Psoriasis

• 100 mg administered by subcutaneous injection at Week 0, Week 4, and every 8 weeks thereafter.

Psoriatic Arthritis

• 100 mg administered by subcutaneous injection at Week 0, Week 4, and every 8 weeks thereafter. TREMFYA can be used alone or in combination with a conventional DMARD (e.g., methotrexate).

Ulcerative Colitis

• Induction: 200 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, and Week 8.

• Maintenance: 100 mg administered by subcutaneous injection at Week 16, and every 8 weeks thereafter, or 200 mg administered by subcutaneous injection at Week 12, and every 4 weeks thereafter.
Use the lowest effective recommended dosage to maintain therapeutic response.

CONTRAINDICATIONS:

TREMFYA is contraindicated in patients with a history of serious hypersensitivity reaction to guselkumab or to any of the excipients

ICD-10*: ____________________________

Dx Code: ____________________________

DOSAGE FORMS AND STRENGTHS:

Use the lowest effective recommended dosage to maintain therapeutic response

Subcutaneous Injection

• Injection: 100 mg/mL in a single-dose One-Press patient-controlled injector.

• Injection: 200 mg/2 mL in a single-dose prefilled pen (TREMFYA PEN).

• Injection: 100 mg/mL in a single-dose prefilled syringe.

• Injection: 200 mg/2 mL in a single-dose prefilled syringe.

Intravenous Infusion

• Injection: 200 mg/20 mL (10 mg/mL) solution in a single-dose vial.

DOSAGE

☐ ________ weeks or x 1 year

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000 MG ☐other _______________

☐ Solumedrol 125mg IV ☐other ________________

☐ Benadryl ☐25mg ☐50mg ☐other __________ ☐IV ☐PO

☐ Medication _________ Dose _______Route _______

☐ ____________________________ (other) ☐ ____________________________ (other)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Recent labs to **include QuantiFERON**, and if have CBC, CMP and Hep B surface antigen please send or any other recent labs

_____ Current Medication List

_____ Other

ORDERING PROVIDER

Signature **X** ________________________________ Date ______________ **NPI**____________________

Provider ______________________ Phone ___________ Fax ______________