Care Fusion INFUSION CENTERS

Gastroenterology #2

Fax: 855-733-9898
Phone: 877-460-3905

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Patient Contact #: _____

Medical Assessment

1. **Diagnosis:** ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____
   ☐ D50.0 Iron deficiency anemia (chronic blood loss) ☐ D50.9 Iron deficiency anemia, unspecified
2. **Drug Allergies:** _____
3. **Failed Medications:** ☐ NSAIDS _____ ☐ MTX _____ ☐ Biologics _____
   (When) ☐ 6-MP _____ ☐ 5-ASA _____ ☐ Corticosteroids _____
   ☐ Sulfasalazine _____ ☐ Azathioprine _____ ☐ Other: _____
4. **Negative TB Skin Test (PPD Test):** ☐ Yes ☐ No When: _____ (Please Attach)

Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis*

Pre-Medication Orders:

- ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion.
- ☐ Diphenhydramine ☐ 25mg ☐ 50mg – PO 30 minutes before infusion.
  ☐ 25mg IVP ☐ 50mg IVP
- ☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
- ☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP OR other _____ mg IVP
- ☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP
- ☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider

Medication

Omvoh (Mirikizumab-mrkz)

- ☐ **Induction (Ulcerative Colitis)**: 300 mg IV at week 0, 4, and 8
- ☐ **Induction (Crohn's Disease)**: 900 mg IV at week 0, 4, and 8
- ☐ **Maintenance (Ulcerative Colitis):** 2 x 100 mg pens SC every 4 weeks from week 12 **Maintenance Refills**: _____
- ☐ **Maintenance (Crohn's Disease):** 100 mg + 200 mg pens SC every 4 weeks from week 12

** Maintenance dosage to be transferred to a Specialty Pharmacy for self -administration order processing **

Skyrizi (Risankizumab-rzaa)

- ☐ **Induction (Crohn's Disease)**: 600 mg IV at week 0, 4, and 8
- ☐ **Induction (Ulcerative Colitis)**: 1200 mg IV at week 0, 4, and 8
- ☐ **Maintenance:** Skyrizi Prefilled Cartridge with On-Body Injector
  Inject ☐ 180mg or ☐ 360mg SQ on week 12, then every 8 weeks **Maintenance Refills**: _____

** Maintenance dosage to be transferred to a Specialty Pharmacy for self -administration order processing **

Stelara (ustekinumab)

- ☐ **Induction:** 260mg Single IV (55 kg or less)
- ☐ **Induction:** 390mg Single IV (over 55 kg to 85 kg)
- ☐ **Induction:** 520mg Single IV (over 85 kg)
- ☐ **Maintenance**: 90mg SC at week 8, then again, every 8 weeks thereafter **Maintenance Refills**: _____

** Maintenance dosage to be transferred to a Specialty Pharmacy for self -administration order processing **

Tremfya (guselkumab)

- ☐ **Induction:** 200 mg Single IV at week 0, 4 and 8
- ☐ **Maintenance:** 100mg SC at week 16 and every 8 weeks thereafter
- ☐ **Maintenance:** 200mg SC at week 12 and every 4 weeks thereafter **Maintenance Refills**: _____

** Maintenance dosage to be transferred to a Specialty Pharmacy for self -administration order processing **

Monoferric (ferric derisomaltose)

- ☐ patient weight of <50kg: 20mg / kg Single IV
- ☐ patient weight of 50 kg or greater: 1000mg Single IV

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ ***Physician Signature:*** _____ ***Date:*** _____