

**Patient Information**

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

Medical Assessment

1. **Diagnosis:** ☐ K50.90 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other: _____
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****Omyvoh (Mirikizumab-mrkz)**

- ☐ **Induction:** 300 mg IV at week 0, 4, and 8
- ☐ **Maintenance:** 2 x 100 mg pens SC injections given every 4 weeks (thereafter) **Maintenance Refills:** _____
- ** 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
- ☐ **Induction:** 390mg Single IV
- ☐ **Induction:** 520mg Single
- ☐ **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 ****

Monoferic (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:** _____