

**PATIENT DEMOGRAPHICS**

**Insurance Information: Please attach copy of insurance card front and back (required)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm

**DIAGNOSIS\***

**ICD-10 CODE (required)**

**Please complete 2nd and 3rd digits to complete ICD-10 for billing**

K51.00 \_\_\_\_\_ Ulcerative (Chronic) Pancolitis without Complications  Other: \_\_\_\_\_, ICD-10 \_\_\_\_\_  
 K51.20 \_\_\_\_\_ Ulcerative (Chronic) Proctitis without Complications

**INFUSION ORDERS**

**MEDICATION**

**DOSE**

**DIRECTIONS/DURATION**

Tremfya® (guselkumab)

200mg

Infuse IV over 1 hour every 4 weeks x 3 doses

Is patient currently receiving therapy above from another facility?  NO  YES

If yes, Facility Name: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

**OTHER ORDERS**

**LAB ORDERS:**

Labs to be drawn by:  Infusion Center  Referring Physician

No labs ordered at this time

CBC q \_\_\_\_\_  CMP q \_\_\_\_\_  CRP q \_\_\_\_\_  ESR q \_\_\_\_\_  LFTs q \_\_\_\_\_  Other: \_\_\_\_\_

**PRE-MEDICATION ORDERS:**

No premeds ordered at this time

Diphenhydramine 25mg PO

Other: \_\_\_\_\_

Acetaminophen 650mg PO

Methylprednisolone 40mg IVP -OR-  Hydrocortisone 100mg IV

**REFERRING PHYSICIAN INFORMATION**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

**REQUIRED CLINICAL DOCUMENTATION**

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis**

**TEST RESULTS (required)**

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
  - Annual TB screening to be done by:  Infusion Center  Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by:  Infusion Center  Referring Physician

**PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)**

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_

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Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_