



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- | | |
|---|--|
| <input type="checkbox"/> K50.0 _____ Crohn's Disease, Small Intestine | <input type="checkbox"/> K51.8 _____ Other Ulcerative Colitis, Chronic |
| <input type="checkbox"/> K50.1 _____ Crohn's Disease, Large Intestine | <input type="checkbox"/> K51.5 _____ Left sided – Ulcerative Colitis |
| <input type="checkbox"/> K50.8 _____ Crohn's Disease, Small & Large Intestine | <input type="checkbox"/> K51.0 _____ Universal Ulcerative Colitis, Chronic |
| <input type="checkbox"/> K50.9 _____ Crohn's Disease, Unspecified | <input type="checkbox"/> K51.9 _____ Ulcerative Colitis, Unspecified |
| <input type="checkbox"/> Other: _____ | |

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy
LAB RESULTS: Include Negative TB within 12 months, baseline liver enzymes and bilirubin

PRESCRIPTION

Pre-Medications

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO | <input type="checkbox"/> Acetaminophen: _____ mg PO |
| <input type="checkbox"/> Cetirizine 10 mg PO | <input type="checkbox"/> Famotidine: _____ mg IV |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV | <input type="checkbox"/> Ondansetron 4 mg IV |
| <input type="checkbox"/> Other: _____ | |

Lab Orders

- CBC w/diff: every _____ weeks month
 CMP: every _____ weeks month
 Other: _____ weeks month

Tremfya (guselkumab)

Loading Dose (SELECT ONE)

- IV: infuse 200 mg at weeks 0, 4, and 8

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

Is the patient on any other disease modifying therapy? Yes No

If yes, please note therapy and last dose: _____

PRESCRIBING INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI # _____ Specialty: _____
 Office phone #: _____ Office Fax #: _____