RELIANT SPECIALTY INFUSION

Gastroenterology #2 **Fax: 833-808-0833**

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

Omvoh (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**: 600 mg IV to infuse over at least 1 hour 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)

- ❑ 260mg Single IV induction dosage per 250ml sodium chloride 0.9% IV to infuse over at least 1 hour with 0.22-micron filter
- ❑ 390mg Single IV induction dosage per 250ml sodium chloride 0.9% IV to infuse over at least 1 hour with 0.22-micron filter
- ❑ 520mg Single IV induction dosage per 250ml sodium chloride 0.9% IV to infuse over at least 1 hour with 0.22-micron filter
- ❑ Maintenance dose of 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 **

Injectafer (ferric carboxymaltose)

- ❑ patient weight of <50kg: 15mg / kg IV on day 0 and 7
- ❑ patient weight of 50 kg or greater: 750mg IV on day 0 and 7

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

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