Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Moderate to severe plaque psoriasis	ICD 10 Code: L40.0
☐ Active psoriatic arthritis	ICD 10 Code: L40.50
☐ Moderately to severely active ulcerative colitis	ICD 10 Code: K51._____
☐ Moderately to severely active Crohn's disease	ICD 10 Code: K50._____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Clinical/Progress Notes (must be within 1 year)
- ☐ Current Medication List

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Labs and Tests supporting primary diagnosis
- ☐ Hepatitis B (HBV) for Plaque Psoriasis and Psoriatic Arthritis
- ☐ Baseline Liver Enzymes and Bilirubin Levels
- ☐ TB test results (must be within 1 year)
- ☐ Patient education to avoid live vaccines

Has patient received and failed at least 2 prior treatments (systemic therapy)? ☐ Yes ☐ No

List Tried & Failed Therapies, including duration of treatment:

1)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: BMI:

☐ J1628 Tremfya Induction: 200mg administered by IV over at least 1 hour at Week 0, Week 4, and Week 8
OR 400mg administered by subcutaneous injection at Week 0, Week 4, and Week 8

☐ Maintenance injections to be managed by referring provider

☐ Other: _____

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

☐ Tylenol 1000mg PO	☐ Solumedrol _____ mg IV
☐ Benadryl _____ mg IV or PO	☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

Labs Orders: _____

Lab Frequency: ☐ Monthly ☐ Other: _____

Lab to be drawn by: ☐ Infusion Center ☐ Referring Provider

PRESCRIBER INFORMATION

Prescriber name :

Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

Effective Date: 2/4/26
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MEDICATION ORDERS - TREMFYA (guselkumab)

Clinics Scan to: Physician Orders