

SKYRIZI (RISANKIZUMAB-RZAA) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

Crohn's Disease, ICD 10: K50. _____ Ulcerative Colitis, ICD 10: K51. _____

Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO

Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Skyrizi	<input type="checkbox"/> 600 mg (Crohn's) <input type="checkbox"/> 1200 mg (UC)	<input type="checkbox"/> IV	<input type="checkbox"/> Weeks 0, 4, 8
	Then <input type="checkbox"/> 180 mg or <input type="checkbox"/> 360 mg	<input type="checkbox"/> Subcutaneous inj.	<input type="checkbox"/> Week 12, then every 8 weeks

x3 IV infusions need to be completed prior to SubQ injections.

Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: CT: 203.433.0621 ME: 207.407.7272 NH: 603.217.5371 NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____