Local Infusion

MYLOCALINFUSION.COM

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	❑ 600 mg (Crohn's) ❑ 1200 mg (UC)	❑ IV	❑ Weeks 0, 4, 8
	Then ❑ 180 mg or ❑ 360 mg	❑ Subcutaneous inj.	❑ Week 12, then every 8 weeks

x3 IV infusions <u>need</u> to be completed prior to SubQ injections.

❑ Please check this box if you <u>DO NOT</u> 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 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

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