PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Crohn's Disease	ICD 10 Code: K50.90
☐ Other: ___________________________	ICD 10 Code: ______

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

☐ The signed order form by the provider
☐ Patient demographics AND insurance information
☐ Prior authorization with reference number

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

☐ Clinical/Progress notes (must be within 1 year)\
☐ Labs and tests supporting primary diagnosis
☐ TB Test results

List of tried and failed therapies, including duration of treatment:
____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _______ WT (kg): _________ BMI: _______

Medication	Dosing/Diluent	Route	Rate of Infusion	Date of administration
☐ J3590 Skirizi for Plaque Psoriasis	150mg/ml prefilled syringe	SQ	N/A	Week 0: __________ Week 4: __________ Every 12 weeks Starting: ________
☐ J3590 Skyrizi for Psoriatic Arthritis	150mg/ml prefilled syringe	SQ	N/A	Week 0: __________ Week 4: __________ Every 12 weeks Starting:
☐ J3590 Skyrizi for Crohn's induction	600mg mixed in D5W as per pharmacy	IVPB	1 hour	Week 0: __________ Week 4: __________ Every 8: ____________________
☐ J3590 Skyrizi for Crohn's Maintenance	360mg/2.4ml prefilled cartridge	SQ	N/A	Week 12 from induction: ______________ Every 8 weeks after week 12 starting: _____________________

Duration: ☐ x6 months ☐ x 1 year ☐ x __________ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____mg PO PRN
☐ Benadryl _____mg PO or IV
☐ Methylprednisolone ______ slow IV push
☐ Other: _________________________

☐ CBC ☐ prior to each infusion or ☐ Frequency: _________
☐ CMP ☐ prior to each infusion or ☐ Frequency: _________
☐ Other: ___________________ Date:___________________

ADDITIONAL ORDERS/INFORMATION

☐ LFT and Bilirubin prior to each dose for Crohn's up to week 12 and PRN thereafter
☐ Hold treatment if the patient has any infections prior to infusion

PRESCRIBER INFORMATION

Provider Name:

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: | Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – SKYRIZI (RISANKIZUMAB-RZAA)