SKYRIZI® Infusion Form

Fax Referral To: 877-438-9380

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ____________________ Next Infusion Date: ____________________

Patient Information

Patient Name:____________________________ DOB: ________________ Sex: ◯ M ◯ F Height: ______ Weight: ________________

Phone Number: ______________________________ Email Address: ______________________________

Allergies: ____ Is the patient Diabetic: Y◯ N◯ ICD-10 Code: ____________________

Emergency Contact:______________________________________ Phone Number: ______________________________

Primary Diagnosis:

_____ Crohn's Disease
_____ Plaque Psoriasis
_____ Psoriatic Arthritis
_____ Other:______________________________

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:
Therapy:____________________**Date:**______________**Therapy:**________________________**Date:**______________
2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:______________**Washout period of** _________ **weeks desired prior to the initiation of this ordered therapy**

Physician Information

Prescribing Physician: ______________________________ Practice Name: ______________________________
Practice Phone: ______________________________ Practice Fax: ______________________________
Email: ______________________________ Office Contact: ______________________________
Co-managing Physician: ______________________________ Phone/Email: ______________________________

Medication Order

Medication: **SKYRIZI® (risankizumab-rzaa)**

☐ ***New Start:***

☐ Skyrizi for Plaque Psoriasis - 150mg/ml prefilled syringe

Week 0___________
Week 4: ___________
Every 12 Weeks starting: _________

☐ Skyrizi for Psoriatic Arthritis - 150mg/ml prefilled syringe

Week 0___________
Week 4: ___________
Every 12 Weeks starting: _________

☐ Skyrizi for Crohn's Induction - 600mg mixed in D5W as per pharmacy

Week 0: ___________
Week 4: ___________
Week 8: ___________

☐ ***Maintenance Dose:***

☐ Skyrizi for Crohn's maintenance - 360mg/2.4ml prefilled cartridge

☐ Skyrizi for Crohn's maintenance - 180mg/1.2ml prefilled cartridge

Week 12 from induction: _________
Every 8 weeks after Week 12 starting: _____________

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ Physician's NPI#

______________________________ Physician's Address

______________________________ Prescriber's Signature

______________________ Date

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