

SKYRIZI

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ K51.9 (Ulcerative Colitis) ☐ K50.9 (Crohn's disease) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT INFORMATION

SKYRIZI (risankizumab-rzaa)

Route: Intravenous Infusion

Dose: ☐ 600mg ☐ 1200mg

Frequency:

☐ Induction (CD): 600mg IV over 1 hour
on weeks 0, 4, and 8

☐ Induction (UC): 1200mg IV over 2 hours
on weeks 0, 4, and 8

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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