

PRESCRIPTION ORDER FORM

SKYRIZI

(rizankizumab)



Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results

PRIMARY DIAGNOSIS

- | | | |
|--|---|---|
| ☐ K50.00 Crohn's disease of small intestine w/o complications | ☐ K50.80 Crohn's disease of both small and large int without complications | ☐ K51.00. Ulcerative chronic pancolitis with 1+ complications |
| ☐ K50.019 Crohn's disease of small intestine with unspecified comps | ☐ K50.819 Crohn's disease of both small and large int w/ unspecified complications | ☐ K51.011 Ulcerative chronic pancolitis with rectal bleeding |
| ☐ K50.10 Crohn's disease of large intestine w/o complication | ☐ K50.90 Crohn's disease, without complication | ☐ K51.80 Other ulcerative colitis without complications |
| ☐ K50.119 Crohn's disease of large intestine with unspecified comps | ☐ K50.919 Crohn's disease, unspecified with unspecified comps | ☐ K51.90 Ulcerative colitis, unspecified without complications |

CLINICAL MONITORING: Recommended lab to be maintained and monitored by prescriber:

- Bilirubin and LFT's during induction around 8-12 weeks

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

- | | |
|---|---|
| ☐ Induction Doses (to be administered in infusion clinic): | Maintenance Doses: |
| ☐ Crohns: Skyrizi 600mg IV at weeks 0, 4, and 8. Infuse over 1 hour | ☐ Skyrizi 180mg subQ at week 12 and every 8 weeks thereafter |
| ☐ UC: Skyrizi 1200mg IV at weeks 0, 4, and 8. Infuse over 2 hours | ☐ Skyrizi 360mg subQ at 12 and every 8 weeks thereafter |
| ☐ <u>Provider's office</u> will coordinate maintenance dose from Specialty Pharmacy. | |
| ☐ Other: _____ | |
- First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

Rev: 2/26