SKYRIZI
(risankizumab)

FLEXCARE INFUSION CENTERS

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
- Baseline liver function tests (if available)

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.019 Crohn's disease of small intestine with unspecified comps
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.119 Crohn's disease of large intestine with unspecified comps
☐ K50.80 Crohn's disease of both small and large int without complications
☐ K50.819 Crohn's disease of both small and large int w/unsp comp
☐ K50.90 Crohn's disease, without complication
☐ K50.919 Crohn's disease, unspecified, with unspecified comps
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
☐ K51.019 Ulcerative (chronic) pancolitis with unsp complications
☐ K51.80 Crohn's disease of both small and lg int w/o complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Skyrizi
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Induction (To be administered in infusion clinic.):
☐ Crohn's: Skyrizi 600mg IV at Weeks 0, 4, and 8
☐ UC: Skyrizi 1200mg IV at Weeks 0, 4, and 8

Maintenance (To be self-administered by patient. No disease-specific dose for Crohn's or UC.):
☐ Skyrizi 180mg subQ via on-body device at Week 12 and every 8 weeks thereafter
☐ Skyrizi 360mg subQ via on-body device at Week 12 and every 8 weeks thereafter

☐ Provider's Office 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 FlexCare Infusion Centers' protocol (See flexcareinfusion.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 FlexCare Infusion Centers' protocol (See flexcareinfusion.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

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals