

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|---------------------------|------------------------|---|---------------------|--------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Most Recent Labs | 5. Medication List |
| 6. Tried/Failed Therapies | 7. Negative TB Results | 8. Baseline liver function tests (if available) | | |

PRIMARY DIAGNOSIS

- | | |
|---|--|
| <input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications | <input type="checkbox"/> K50.919 Crohn's disease, unspecified, with unspecified comps |
| <input type="checkbox"/> K50.019 Crohn's disease of small intestine with unspecified comps | <input type="checkbox"/> K51.00 Ulcerative (chronic) pancolitis without complications |
| <input type="checkbox"/> K50.10 Crohn's disease of large intestine without complications | <input type="checkbox"/> K51.011 Ulcerative (chronic) pancolitis with rectal bleeding |
| <input type="checkbox"/> K50.119 Crohn's disease of large intestine with unspecified comps | <input type="checkbox"/> K51.019 Ulcerative (chronic) pancolitis with unsp complications |
| <input type="checkbox"/> K50.80 Crohn's disease of both small and large int without complications | <input type="checkbox"/> K51.80 Other ulcerative colitis without complications |
| <input type="checkbox"/> K50.819 Crohn's disease of both small and large int w/unsp comp | <input type="checkbox"/> K51.90 Ulcerative colitis, unspecified, without complications |
| <input type="checkbox"/> K50.90 Crohn's disease, without complication | <input type="checkbox"/> Other _____ |

LABS 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.): | Maintenance (To be self-administered by patient. No disease-specific dose for Crohn's or UC.): |
| <input type="checkbox"/> Crohn's: Skyrizi 600mg IV at weeks 0, 4, and 8 | <input type="checkbox"/> Skyrizi 180mg subQ via on-body device at week 12 and every 8 weeks thereafter |
| <input type="checkbox"/> UC: Skyrizi 1200mg IV at weeks 0, 4, and 8 | <input type="checkbox"/> Skyrizi 360mg subQ via on-body device at week 12 and every 8 weeks thereafter |
| <input type="checkbox"/> Provider's Office will coordinate maintenance dose from Specialty Pharmacy | |
| <input type="checkbox"/> Other: _____ | |
- FIRST DOSE?: Yes No Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____