LIFE
SPECIALTY SOLUTIONS

SKYRIZI
(risankizumab)

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

☐ 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 cmplication
☐ 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 Other ulcerative colitis withoutcomplications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ 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.):
☐ 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?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: ______

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

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

✖ ______
PROVIDER SIGNATURE

______
DATE