SKYRIZI (risankizumab)

New Prescription/Referral
Prescription Refill

 # Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

Skyrizi:
(risankizumab)

Initial Dose (to be administered in infusion clinic):

☐ 600mg IV at weeks 0, 4, and 8 ☐ 1200mg IV at weeks 0, 4, and 8

Maintenance Doses (to be self-administered by patient):

☐ 180mg SubQ at week 12, then every 8 weeks thereafter x 1 year

☐ 360mg SubQ at week 12, then every 8 weeks thereafter x 1 year

☐ Others: _____

_____

Pre-Medication:

☐ Solumedrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Others: _____

☐ Tylenol _____ mg PO

☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO

☐ 25 mg ☐ IV

☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis: ☐ Ulcerative Colitis (UC) ☐ Crohn's Disease

☐ Other: _____

ICD-10: _____

Physician Signature

NPI #:

DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

Clinic:

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical

☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results

☐ TB screening test within 12 months - attach results ☐ Baseline liver function tests and bilirubin - attach results

If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.