Skyrizi®
Referring Physician Orders Rev. 4/2026
Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: ______________________ DOB: ______________ Phone: ______________
Address: ______________________ City/ST/Zip: ______________________
Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ K51.0 _____ Ulcerative (Chronic) Pancolitis without Complications
☐ K51.2 _____ Ulcerative (Chronic) Proctitis without Complications
☐ Other: ______________________, ICD-10 ________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Skyrizi® (risankizumab)	☐ 600mg (for CD) ☐ 1200mg (for UC)	☐ CD: Infuse 600mg IV over 1 hour every 4 weeks x 3 doses ☐ UC: Infuse 1200mg IV over 2 hours every 4 weeks x 3 doses

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES
If yes, Facility Name: ______________________ Date of last treatment: ____________ Date of next treatment: ____________

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time
☐ CBC q ________ ☐ CMP q ________ ☐ CRP q ________ ☐ ESR q ________ ☐ LFTs q ________ ☐ Other: ____________

PRE-MEDICATION ORDERS:
☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: ____________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ____________
Physician Name: ______________ Provider NPI: ______________ Specialty: ______________
Address: ______________________ City/ST/Zip: ______________
Contact Person: ______________ Phone #: ______________ Fax #: ______________
Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- TB Screening for Cimzia, Entyvio, infliximab biosimilars, Omvoh, Skyrizi, Stelara and Tremfya (submit results from within 12 months to start and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening for Cimzia and infliximab biosimilars (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________
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