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***

☐ K51.00 _____ Ulcerative (Chronic) Pancolitis without Complications
☐ K51.20 _____ 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 ☐ Diphenhydramine 25mg PO ☐ Other: _____
☐ Acetaminophen 650mg PO ☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV

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