

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 Complications
- K51.2 _____ Ulcerative (Chronic) Proctitis
- K51.3 _____ Ulcerative (Chronic) Rectosigmoiditis
- K51.4 _____ Inflammatory Polyps of Colon
- K51.5 _____ Left Sided Colitis
- K51.8 _____ Other Ulcerative Colitis or Unspecified
- Ulcerative Colitis, unspecified
- Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION

Skyrizi® (risankizumab-rzaa)
for Ulcerative Colitis (UC)

DOSE

- Initial: 1200mg
- Maintenance: 180mg
- Maintenance: 360mg

DIRECTIONS / DURATION

- Initial: IV over at least two hours at week 0, week 4 and week 8
- Maintenance: SQ at week 12 and every 8 weeks thereafter

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: _____
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