medix infusion

Skyrizi IV Order Form
(Risankizumab-rzaa)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

- ☐ K50.00 Crohn's Disease, Small Intestine
- ☐ K50.10 Crohn's Disease, Large Intestine
- ☐ K50.80 Crohn's Disease, Small and Large Intestine
- ☐ K50.90 Crohn's Disease, Unspecified
- ☐ K51.10 Ulcerative Colitis, Unspecified
- ☐ Other: _____

Patient status:

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose _____)

Weight: _____ ☐ lb ☐ kg **Height:** _____

Allergies: _____

PRESCRIPTION

SKYRIZI IV (risankizumab-rzaa)

Loading Dose: Crohn's Disease

☐ 600 mg IV at Weeks 0, 4, and 8

Loading Dose: Ulcerative Colitis

☐ 1200 mg IV at Weeks 0, 4, and 8

Lab Orders (Required)

Negatuve TB, Liver Enzymes, and bilirubin at weeks 0 and

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Other Orders:

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____