

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

K50.0 _____ Crohn's Disease, Small Intestine	K51.9 _____ Ulcerative Colitis, Unspecified
K50.1 _____ Crohn's Disease, Large Intestine	K51.01 _____ Ulcerative (Chronic) Pancolitis with Complications
K50.8 _____ Crohn's Disease, Small and Large Intestine	K51.90 _____ Ulcerative Colitis, Unspecified, without Complications
K50.9 _____ Crohn's Disease, Unspecified	K-51.019 _____ Ulcerative (Chronic) Pancolitis with Unspecified Complications

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Include Negative TB within 12 months.

PRESCRIPTION

SKYRIZI IV (risankizumab-rzaa)

Loading Dose IV

Infuse 600 mg in 250 ml of 5% Dextrose over at least 1 hour at weeks 0, 4, and 8

Lab Orders+

Required: Negative TB, Liver enzymes and bilirubin at weeks 0 and 4

+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

Is the patient on any other disease modifying therapy? Yes No
 If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

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

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Supervising Physician: _____ (If Applicable)
 Address: _____ City: _____ State: _____ Zip: _____
 Contact Name: _____ Phone: _____ Fax: _____ Email: _____