medix infusion

Skyrizi® IV Order Form
(risankizumab-rzaa)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

Diagnosis

ICD 10 Code Required

☐ Moderate to Severe Crohn's Disease (K50.00-K50.919), ICD 10 _____

☐ Moderate to Severe Ulcerative Colitis (K51.00-K51.919), ICD 10 _____

Infusion Orders

DOSE | DIRECTIONS | DURATION

☐ (Crohn's Disease) 600mg IV at week 0, 4, and 8

☐ (Ulcerative Colitis) 1200mg IV at week 0,4, and 8

Is patient currently receiving therapy above from another facility?

☐ YES ☐ NO

If yes, Facility Name: _____

Date of last treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 125mg SIVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Medix Infusion ☐ Referring Physician

☐ No labs ordered at this time

☐ Liver Enzyme q _____ ☐ Billirubin q _____

☐ Annual TB Screening

☐ Other: _____

Required Clinical Documentation

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

LAB AND TEST RESULTS

- Provide copy of negative TB result (QuntiFeron Gold, T-spot, PPD, TST, CXR) within 1 year of therapy initiation
- Provide copy of Liver Enzymes and Billirubin

PRIOR FAILED THERAPIES (including corticosteroids, antimalarials, NSAIDS, immunosuppressants)

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

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Prescriber Information

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____