TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

SKYRIZI ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

Please check any of the following that apply:

☐ *New Start*

☐ *Continuing Therapy:*

Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Skyrizi	☐ Crohn's Disease Induction Phase: Administer Skyrizi 600mg IV at week 0, week 4 and week 8 per protocol. ☐ Crohn's Disease Maintenance Phase: Administer Skyrizi 360mg SQ at week 12 and every 8 weeks thereafter.	***Refills x one year from date of signature unless indicated below.*** ☐ _____ Refills	**Please include the following lab results required for infusion. If no results are available, the following labs will be drawn:** ✓ *Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months.* ✓ *ALT/AST at baseline (within the past 60 days), then again at week 4 dose and week 8 dose.* ✓ *Bilirubin at baseline (within the past 60 days), then again at week 4 dose and week 8 dose.*

PRE-MEDICATIONS

Oral

☐ Acetaminophen: ___325mg ___500mg __650mg
☐ Loratadine: 10 mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: ___25mg ___50mg
☐ Famotidine: ___20mg ___40mg
☐ Ibuprofen: ___200mg ___400mg ___600mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

IV

☐ Dexamethasone: ___4mg ___8mg
☐ Diphenhydramine: ___25mg __50mg
☐ Famotidine: ___20mg ___40mg
☐ Methylprednisolone 125mg
☐ Hydrocortisone 100mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

LAB ORDERS (Please indicate any labs to be drawn and frequency)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 8.2.22