TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS™

SKYRIZI ORDER FORM

Date: ___________________________	ICD-10 Code: ___________________________
Patient Name: ___________________________	Allergies: ___________________________
Date of Birth: ___________________________	Weight: __________ lbs OR __________ kg

Therapy Status	**Provider Information**
Please check any of the following that apply:	Ordering Provider: ____________________
☐ *New Start*	Provider NPI: ____________________
☐ *Continuing Therapy:*	Provider Phone: ____________________
Last Dose: ____________________	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	IV
☐ Acetaminophen: ___325mg ___500mg __650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other____________________
☐ Other____________________	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
  Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(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:	Substitution Allowed:
____________________ ________ Prescriber Name Date	____________________ ________ Prescriber Name Date