

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



SKYRIZI ORDER FORM

Date: _____	ICD-10 Code: _____	<p style="text-align: center;">Therapy Status</p> <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Skyrizi	<input type="checkbox"/> Crohn's Disease Induction Phase: Administer Skyrizi 600mg IV at week 0, week 4 and week 8 per protocol. <input type="checkbox"/> Crohn's Disease Maintenance Phase: Administer Skyrizi: <input type="checkbox"/> 180mg SQ at week 12 and every 8 weeks thereafter. <input type="checkbox"/> 360mg SQ at week 12 and every 8 weeks thereafter.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p><i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i></p> <input checked="" type="checkbox"/> Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months. <input checked="" type="checkbox"/> ALT/AST at baseline (within the past 60 days), then again at week 4 dose and week 8 dose. <input checked="" type="checkbox"/> Bilirubin at baseline (within 60 days), then again at week 4 dose and week 8 dose.
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PRE-MEDICATIONS

<p><u>Oral</u></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><u>IV</u></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

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) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written: _____ _____ Prescriber Name	Substitution Allowed: _____ _____ Prescriber Name
_____ Date	_____ Date