

**TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**SKYRIZI ORDER FORM**

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

**PROVIDER INFORMATION**

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

**MEDICATION ORDER**

<b>Skyrizi</b>	<input type="checkbox"/> Crohn's Disease Induction Phase: Administer Skyrizi 600mg IV over at least one hour at week 0, week 4 and week 8.  <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.  <input type="checkbox"/> Ulcerative Colitis Induction Phase, Administer Skyrizi: <input type="checkbox"/> 1,200mg IV over at least two hours at week 0, week 4 and week 8.  <input type="checkbox"/> Ulcerative Colitis 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 for one year from date of signature unless indicated below.  _____ Refills	<p><b><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></b></p> <p>✓ Negative TB result and date: _____</p> <p>✓ ALT/AST at baseline; Bilirubin at baseline</p>
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**PRE-MEDICATIONS**

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

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

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