



Skyrizi® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com Initial Order Reorder

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

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

Phone #: _____ Cell Alternate Phone #: _____ Cell

Height: _____ in/ft **Weight:** _____ lbs/kg Date weight recorded: _____ **Last 4 of SSN:** _____

Allergies: _____ NKDA

Diagnosis Information: Crohn's of small intestine w/o complications K50.00 Crohn's disease of large intestine without complications K50.10 Crohn's of small and large intestine without complications K50.80

Other Diagnosis/ICD10Code _____

Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? Yes No HTN? Yes No Cardiac History? Yes No Difficulty Breathing? Yes No

Requires Oxygen? Yes No Confusion /Disorientation? Yes No Neuro History? Yes No

Date of Negative TB test: _____

Skyrizi® (Risankizumab-rzaa): J2327 **Hepatic panel should be monitored during duration of therapy by physician per PI**

Induction dose: 600mg IV at 0, 4, and 8 weeks.

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion.

Benadryl 25 MG PO x1 Benadryl 50 mg PO x1

Acetaminophen 325 mg PO x1 Acetaminophen 650 mg PO x1

Other Pre-medication: _____

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 3</p> <p>PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer medications</p> <p>Administer the anaphylaxis protocol for adverse reactions</p>
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Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St _____ Zip: _____

Printed MD Name: _____ Contact Name: _____

Demographic information Patient Ins. Card H & P Office notes Failed therapies in documentation

Up to date medication list

1/24 ARG