Skyrizi® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Crohn's Disease
_____ Plaque Psoriasis
_____ Psoriatic Arthritis
_____ Other: _____

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:
Therapy:_____Date:_____Therapy:_____Date:_____
2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:_____Washout period of _____ weeks desired prior to the initiation of this ordered therapy

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **SKYRIZI® (risankizumab-rzaa)**

☐ ***New Start:***

☐ Skyrizi for Plaque Psoriasis - 150mg/ml prefilled syringe
Week 0_____
Week 4: _____
Every 12 Weeks starting: _____

☐ Skyrizi for Psoriatic Arthritis - 150mg/ml prefilled syringe
Week 0_____
Week 4: _____
Every 12 Weeks starting: _____

☐ Skyrizi for Crohn's Induction - 600mg mixed in D5W as per pharmacy
Week 0: _____
Week 4: _____
Week 8: _____

☐ ***Maintenance Dose:***

☐ Skyrizi for Crohn's maintenance - 360mg/2.4ml prefilled cartridge
☐ Skyrizi for Crohn's maintenance - 180mg/1.2ml prefilled cartridge
Week 12 from induction: _____
Every 8 weeks after Week 12 starting: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date