BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

SKYRIZI (RISANKIZUMAB) ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

Diagnosis: ☐ Crohn's Disease ☐ Other:_____

ICD-10 Code:_____

THERAPY ORDER

Skyrizi

☐ IV induction dose: 600mg IV at week 0, 4, and 8

☐ Maintenance dose: 180mg/360mg subcutaneously at week 12, then every 8 weeks thereafter x 1 year (to be evaluated by Biocare Infusion Specialty Pharmacy)

Lab Orders: _____

****LFTs and Bilirubin should be monitored at baseline, during induction, and periodically****

Lab frequency**:** ☐ Prior to 4 and 8 week dose ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider ☐ Home Health

Other orders: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR SKYRIZI THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Does the patient have a contraindication/intolerance or failed trial to corticosterioids or immunomodulators (i.e., 6-MP, azathioprine, budesonide)? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ Does the patient have a contraindication/intolerance or failed trial to any biologic (i.e., Humira, Remicade, Stelara, Cimzia)? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Skyrizi.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **TB screening test completed - attach results**
☐ **Positive** ☐ **Negative**

☐ **Baseline liver function tests and bilirubin - attach results**

If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance