SKYRIZI® (risankizumab) Referral Form

Patient Preferred Clinic (select one): _____

VIVO infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ OTHER

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
Other: _____
Dose: _____ Route: _____

SKYRIZI THERAPY ADMINISTRATION

☐ 600mg IV at week 0, 4 and 8

☐ 1,200 mg IV at week 0, 4 and 8

REQUIRED DOCUMENTATION

☐ **Patient Demographics**

☐ **Insurance Card/Information**

☐ **Progress Notes Supporting DX**

☐ **Medication List and H&P**

☐ **Liver Function Tests/Bilirubin within 1 year**

☐ **TB Results within 6 months**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Colorado: 303-418-4679
☐ Connecticut: 203-724-4838
☐ Florida: 904-930-4211
☐ Nevada: 702-489-5744
☐ Massachusetts: 800-540-1852
☐ New Jersey: 609-955-3711
☐ New York: 800-540-1852
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Pennsylvania: 215-399-9244
☐ Texas: 469-340-0044
☐ Virginia: 804-500-5941