INTRAMED Plus
infusion services

SKYRIZI®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Crohn's Disease ICD-10 Code: K50._____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Recent Lab Results including any recent antibody testing results (i.e. TB Screening Results)
- Medication List
- Previous Drug Therapy History, including therapies trialed and/or failed and date of last infusion_____

Patient
Weight: _____ lbs.
Height:_____ in.

❑ Washout period of _____weeks desired prior to the initiation of this ordered therapy

---

4. Drug Order: **SKYRIZI® (risankizumab-rzaa)** J Code: J2327

❑ **Induction**

Administer 600 mg intravenously over at least one hour at weeks 0, 4, and 8. Dose Authorized: 3

❑ **Maintenance**

❑ Administer 180 mg subcutaneously on week 12 and then every 8 weeks thereafter

❑ Administer 360 mg subcutaneously on week 12 and then every 8 weeks thereafter

_____ # Refills (Recommend 8)

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

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

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name with Credentials:_____ NPI: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760