

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Baseline liver function tests (if available)

PRIMARY DIAGNOSIS

- K50.00 Crohn's disease of small intestine without complications
- K50.019 Crohn's disease of small intestine with unspecified comps
- K50.10 Crohn's disease of large intestine without complications
- K50.119 Crohn's disease of large intestine with unspecified comps
- K50.80 Crohn's disease of both small and large int without complications
- K50.819 Crohn's disease of both small and large int w/unsp comp
- K50.90 Crohn's disease, without complication
- K50.919 Crohn's disease, unspecified, with unspecified comps
- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
- K51.019 Ulcerative (chronic) pancolitis with unsp complications
- K51.80 Crohn's disease of both small and lg int w/o complications
- K51.90 Ulcerative colitis, unspecified, without complications
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

Baseline LTFs as needed

Other: _____

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds for Skyrizi

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Induction (To be administered in infusion clinic.): **Maintenance** (To be self-administered by patient. No disease-specific dose for Crohn's or UC.):

Crohn's: Skyrizi 600mg IV at Weeks 0, 4, and 8 Skyrizi 180mg subQ via on-body device at Week 12 and every 8 weeks thereafter

UC: Skyrizi 1200mg IV at Weeks 0, 4, and 8 Skyrizi 360mg subQ via on-body device at Week 12 and every 8 weeks thereafter

Provider's Office will coordinate maintenance dose from Specialty Pharmacy

Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy) Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND LICENSE:	<input type="checkbox"/> Email:

Provider Signature

Date