

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	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 | ☐ K50.919 Crohn's disease, unspecified, with unspecified comps |
| ☐ K50.019 Crohn's disease of small intestine with unspecified comps | ☐ K51.00 Ulcerative (chronic) pancolitis without complications |
| ☐ K50.10 Crohn's disease of large intestine without complications | ☐ K51.011 Ulcerative (chronic) pancolitis with rectal bleeding |
| ☐ K50.119 Crohn's disease of large intestine with unspecified comps | ☐ K51.019 Ulcerative (chronic) pancolitis with unsp complications |
| ☐ K50.80 Crohn's disease of both small and large int without complications | ☐ K51.80 Other ulcerative colitis without complications |
| ☐ K50.819 Crohn's disease of both small and large int w/unsp comp | ☐ K51.90 Ulcerative colitis, unspecified, without complications |
| ☐ K50.90 Crohn's disease, without complication | ☐ 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:	☐ Fax:
NPI AND LICENSE:	☐ Email:

Provider Signature

Date