Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ Psoriatic Arthritis	ICD 10 Code: L40.50
☐ Crohn's Disease	ICD 10 Code: K50.90

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis
☐ Confirmed negative TB testing
☐ LFT and Bilirubin prior to each dose for Crohn's up to week 12 and PRN thereafter.

List Tried & Failed Therapies, including duration of treatment:
1) 2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Medication	Dosing/Diluent	Route	Rate of Infusion	Dates of administration
☐ J3590 Skyrizi for Plaque Psoriasis	150mg/ml prefilled syringe	SQ	N/A	Week 0: _____ Week 4: _____
☐ J3590 Skyrizi for Psoriatic Arthritis	150mg/ml prefilled syringe	SQ	N/A	Every 12 Weeks starting: _____
☐ J3590 Skyrizi for Crohn's induction	600mg mixed in D5W as per pharmacy	IVPB	1 hour	Week 0: _____ Week 4: _____ Week 8: _____
☐ J3590 Skyrizi for Crohn's maintenance	360mg/2.4ml prefilled cartridge	SQ	N/A	Week 12 from induction: _____ Every 8 weeks after Week 12 starting: _____

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

Hold treatment if the patient has any infections prior to infusion

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - SKYRIZI® (risankizumab-rzaa)

Clinics Scan to: Physician Orders