Skyrizi IV (risankizumab-rzaa)

☐ New Referral ☐ Continuing Treatment ☐ Medication Order Change

Patient Information:

Name:_____
Date:_____
DOB:_____
SS#:_____
Phone #:_____
Email:_____

Physician Information:

Referring Physician: _____

Address:_____
_____

Phone #:_____

Fax #:_____

Medication Orders

Patient Weight: _____kg Patient Height: _____inches ☐ First Dose: Initial IV Load Dose

Dosing: ☐ **LOADING DOSE IV:**

☐ **600mg IV @ week 0, week 4, and week 8 over 1 hour**

☐ **1200mg IV @ week 0, week 4, and week 8 over 2 hours**

Indication / Diagnosis:

☐ K50.____ Crohn's Disease
☐ K51._____ Ulcerative Colitis
ICD-10 (Required) _____

MD Signature: _____NPI#:_____ Date: _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

Main Office
Bay Ridge - Brooklyn
9711 3rd Avenue
Brooklyn, NY 11290
Phone: 718-400-9924 Fax: 718-586-5146
newpatient@bhinfusion.com