BARNES HEALTHCARE SERVICES

Skyrizi® (risankizumab-rzaa) Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient
Patient's first name _____ **Last name** _____ **MI** _____
Preferred patient first name _____ **Preferred patient last name** _____
Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____
Last 4 of SSN _____ **Date of birth** _____/_____/_____
Street address _____ **Apt #** _____
City _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **Email address** _____
Parent/guardian (if applicable)
Home phone _____ **Cell phone** _____ **Email address** _____
Alternate caregiver/contact
Home phone _____ **Cell phone** _____ **Email address** _____
☐ OK to leave message with alternate caregiver/contact
Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____
Office/clinic/institution name
Prescriber's first name _____ **Last name** _____
Prescriber's title _____ **If NP or PA, under direction of Dr.** _____
Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____
Office contact and title _____ **Office contact email** _____
Office street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site
If infusion site, complete information below:
Infusion site name _____ **Clinic/hospital affiliation** _____
Site street address _____ **Suite #** _____
City _____ **State** _____ **Zip** _____
Infusion site contact _____ **Phone** _____ **Fax**
Email _____
Note: Check the appropriate shipment options in Section 4: Prescribing Information.

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3 Clinical Information

Primary ICD-10 code (REQUIRED):_____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies** _____

Concurrent meds: _____

4 Prescribing Information

Medication	Strength / Formulation	Directions	Quantity / Refills
Skyrizi® (risankizumab-rzaa) — Crohn's Disease			
Skyrizi® — Crohn's — Starter dose	600mg/10mL vial	Infuse 600mg IV at weeks 0, 4 and 8 ☐ Patient does not need loading dose If patient needs partial loading dose, indicate what is needed: ☐ Week 4 and week 8 ☐ Week 8 only	1 vial ____ Refills (Max. 2)
Skyrizi® — Crohn's — Maintenance dose	☐ 180mg/1.2mL prefilled cartridge with On-Body Injector (OBI) ☐ 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI)	☐ Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter ☐ Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter Use the lowest effective dosage to maintain therapeutic response.	1 box (1 pre-filled cartridge + 1 OBI) ____ Refills
— OR —			
Skyrizi® (risankizumab-rzaa) — Ulcerative Colitis			
Skyrizi® — UC — Starter dose	600mg/10mL vial	Infuse 1200mg IV at weeks 0, 4 and 8 ☐ Patient does not need loading dose If patient needs partial loading dose, indicate what is needed: ☐ Week 4 and week 8 ☐ Week 8 only	2 vials ____ Refills (Max. 2)
Skyrizi® — UC — Maintenance dose	☐ 180mg/1.2mL prefilled cartridge with On-Body Injector (OBI) ☐ 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI)	☐ Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter ☐ Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter Use the lowest effective dosage to maintain therapeutic response.	1 box (1 pre-filled cartridge + 1 OBI) ____ Refills

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication. *(S9359, S9379)*

Prescriber's signature required (sign on next page) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ **Dispense as written** **Date** _____ ☐ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

If NP or PA, under direction of Dr. _____ **License #:** _____

If NP or PA, under direction of Dr. _____ **License #:** _____

5 Additional Prescribing Information for Home Infusions *Only*

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders

☐ Acetaminophen 650mg PO 30 min prior to infusion ☐ Diphenhydramine 50mg PO 30 min prior to infusion

☐ Other _____

Infusion method: ☐ Gravity

Fluids for administration and reconstitution (please strike through if not required)

Fluid options should be as follows:

☐ Dilution: NS 0.9% 100mL for Crohn's or 250mL for Ulcerative Colitis

☐ NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access:

☐ Flush with 10mL Sterile NS 0.9% before and after infusion ☐ Follow with heparin 100 units/mL 5mL final flush

If peripheral access:

☐ Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity / Anaphylaxis:

☐ Stop infusion

Medicate with:

☐ Epinephrine / EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

☐ Start NS 0.9% 100mL at TKO ☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis

☐ Methylprednisolone 125mg slow IVP PRN anaphylaxis ☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis

☐ Diphenhydramine 50mg PO PRN anaphylaxis ☐ Other _____

Send quantity and refills sufficient for medication days supply.

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

**If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.*

Lab orders _____ **Frequency**

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

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Date _____ ☐ **Dispense as written** **Date** _____ ☐ **Substitution allowed**

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