CoxHealth at Home

Skyrizi ®

(risankizumab)

Phone: 1-855-419-4663

Fax: 1-417-269-0692

Patient Information

Name:_____ DOB:_____

Height: _____ ❑ in ❑ cm Weight_____ ❑ kg ❑ lbs

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Alternate:_____

SSN:_____

PLEASE INCLUDE ON FAX A COPY OF FRONT AND BACK OF INSURANCE CARD(S)

Prescriber

Prescriber name:_____

NPI: _____

Address:_____

_____

City:_____ State:_____ Zip:_____

Contact:_____

Phone:_____ Fax:_____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: Diagnosis: ❑ K50.90 (Crohn's disease)

❑ Other: _____

Allergies:_____

Intravenous Skyrizi®

Flushing/Premedication Orders:

✓ Flushing per CoxHealth at Home protocol

- ✓ PIV: 0.9% sodium chloride 3-20mL before and after infusion as needed
- ✓ Port: 0.9% sodium chloride 3-20mL into port at time of access or at least monthly, 0.9% sodium chloride 3-20mL before and after infusion as needed, Heparin 100 units/mL 5mL as lock after infusion

✓ No routine premedication necessary. If desired, please write here: _____

Skyrizi® (risankizumab) IV over at least 60 minutes

Frequency: ❑ 3 doses, at weeks 0, 4, and 8 (to be followed in 4 weeks by subcutaneous dosing—please send additional prescription for subcutaneous product) OR

❑ Other: _____

✓ **Dose:** 600mg

Dilute in dextrose 5% in water to a final concentration of 1.2-6mg/mL.

Quantity to dispense: ❑ 3 doses OR ❑ __ infusion(s)

Labs: every _____ (frequency) ❑ CBC with diff ❑ CMP ❑ Other:_____

Prescriber's Signature:_____ Date_____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.