



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)	
Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION
<input type="checkbox"/> L40.0 Plaque Psoriasis (Ps) <input type="checkbox"/> L40.52 Psoriatic Arthritis Mutilans <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other Diagnosis/ICD-10 Code: _____ TB Test (Date): ____/____/____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Lab Orders: _____ Frequency: _____

**SKYRIZI™ ORDERS**

Prescription type:  New start   
 Restart   
 Continued therapy   
 Total Doses Received: \_\_\_\_\_   
 Date of Last Injection/Infusion: \_\_\_\_\_

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Skyrizi™ (risankizumab) – Chron's Disease Indicated	<input type="checkbox"/> Loading dose: 600mg/10mL vial <input type="checkbox"/> Infuse 600mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____	Refills: _____
<input type="checkbox"/> Skyrizi™ (risankizumab) – Psoriasis Indicated	<input type="checkbox"/> 150 mg (via one 150 mg injection or two 75 mg injections) subcutaneously at week 0 and week 4, followed by 150 mg subcutaneously every 12 weeks <input type="checkbox"/> Other: _____	Refills: _____
<input type="checkbox"/> Skyrizi™ (risankizumab) – Ulcerative Colitis Indicated	<input type="checkbox"/> Loading Dose: 600mg/10mL vial <input type="checkbox"/> 1200mg IV on week 0, 4, 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____	Refills: _____

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Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____	_____	_____

**INFUSION REACTION ORDERS**

**Mild reaction protocol:**

- Diphenhydramine 25mg IV, one time, for pruritus.
- If symptoms worsen, see orders for moderate to severe reactions.*

**Moderate reaction protocol:**

- Acetaminophen 650mg PO, one time, for pyrexia or rigors
- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms
- If symptoms worsen, see interventions for severe reactions*

**Severe reaction protocol: (Call 911 if initiated):**

- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

**FLUSHING & LOCKING ORDERS**

Flushing Protocol (>66lbs/33kg)

**PIV and Midline:**

- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:**

- 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

**PIV and Midline:**

- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

**PICC:**

- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:**

- Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**\*\* May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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