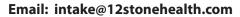
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SKYRIZI ORDER FORM						
Date:		ICD-10 Code:			Therapy Status ☐ New Start	
Patient Name:					☐ Continuing Therapy: Last Dose:	
Date of Birth:						
PROVIDER INFORMATION						
Ordering Provider: Pr				Provider Fax:		
Provider NPI:			Provider Address:			
Provider Phone:						
MEDICATION ORDER						
Skyrizi	 □ Crohn's Disease Induction Phase: Administer Skyrizi 600mg IV over at least one hour at week 0, week 4 and week 8. □ Crohn's Disease Maintenance Phase, Administer Sky □ 180mg SQ at week 12 and every 8 weeks thereafte □ 360mg SQ at week 12 and every 8 weeks thereafte □ Ulceritive Colitis Induction Phase, Administer Skyrizi: □ 1,200mg IV over at least two hours at week 0, wee and week 8. □ Ulceritive Colitis Maintenance Phase, Administer Skyr □ 180mg SQ at week 12 and every 8 weeks therafter □ 360mg SQ at week 12 and every 8 weeks therafter 		er. er. ek 4 rizi: r.	Refills for from c signature indicated	date of e unless d below.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months. ✓ ALT/AST at baseline (within the past 60 days). ✓ Bilirubin at baseline (within 60 days).
	PRE-MEDICATIONS					
Oral IV						
□ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg				□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg		
□ Ondansetron:4mg8mg				Other:		
Other:						NUIDED DOCUMENTATION
LAB ORDERS (please indicate any labs to be drawn and frequency) **Surveillance lab ordering and monitoring is the responsibility of the prescriber**			to 8 • Hi • Pa	OTHER REQUIRED DOCUMENTATION (Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work		
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.						
Dispense as Written:			Sub	Substitution Allowed:		
Prescriber	ber Name Date		Pre	Prescriber Name		 Date