TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

SKYRIZI ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ 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 Skyrizi:
- ☐ 180mg SQ at week 12 and every 8 weeks thereafter.
- ☐ 360mg SQ at week 12 and every 8 weeks thereafter.

☐ Ulceritive Colitis Induction Phase, Administer Skyrizi:
- ☐ 1,200mg IV over at least two hours at week 0, week 4 and week 8.

☐ Ulceritive Colitis Maintenance Phase, Administer Skyrizi:
- ☐ 180mg SQ at week 12 and every 8 weeks therafter.
- ☐ 360mg SQ at week 12 and every 8 weeks therafter.

Refills for one year from date of signature unless indicated below.

_____ Refills

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

- ☐ Acetaminophen: ____ 325mg ____ 500mg ____ 650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ____ 25mg ____ 50mg
- ☐ Famotidine: ____ 20mg ____ 40mg
- ☐ Ibuprofen: ____ 200mg ____ 400mg ____ 600mg
- ☐ Ondansetron: ____ 4mg ____ 8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: ____ 4mg ____ 8mg
- ☐ Diphenhydramine: ____ 25mg ____ 50mg
- ☐ Famotidine: ____ 20mg ____ 40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ____ 4mg ____ 8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

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:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date