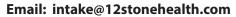
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SKYRIZI ORDER FORM							
Date:		ICD-10 Code:		New		Therapy Status	
Patient Name:		Allergies:					
Date of Birth:		Weight:Ibs OR	kg		☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION							
Ordering Provider:			Prov	Provider Fax:			
Provider NPI:			Prov	Provider Address:			
Provider Phone:							
MEDICATION ORDER							
Skyrizi	□ Crohn's Disease Induction Administer Skyrizi 600mg hour at week 0, week 4 ar □ Crohn's Disease Maintena □ 180mg SQ at week 12 a □ 360mg SQ at week 12 a □ Ulceritive Colitis Induction □ 1,200mg IV over at leas and week 8. □ Ulceritive Colitis Maintenar □ 180mg SQ at week 12 a □ 360mg SQ at week 12 a	IV over at least one ad week 8. Ince Phase, Administer Shand every 8 weeks therea and every 8 weeks therea Phase, Administer Skyriz t two hours at week 0, we are Phase, Administer Sk and every 8 weeks theraft	fter. fter. : eek 4 yrizi: er.	Refills for different disagnature indicated	ate of unless 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:  Very Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.  Very ALT/AST at baseline (within the past 60 days).  Very Bilirubin at baseline (within 60 days).	
PRE-MEDICATIONS							
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:				IV       □ Dexamethasone:4mg8mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Methylprednisolone: 125mg         □ Hydrocortisone: 100mg         □ Ondansetron:4mg8mg         □ Other:			
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION			
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**			to :	<ul> <li>(Please fax this signed order form, along with the following documents to 800-223-4063)</li> <li>History &amp; Physical, Last Office Visit Note</li> <li>Patient Demographics and Insurance Information</li> <li>Medication List</li> <li>Recent Lab Work</li> </ul>			
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:				Substitution Allowed:		<del></del>	
Prescriber	r Signature Date		Pro	Prescriber Signature		 Date	