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 Signature Date

Substitution Allowed:

______________________ ______________
Prescriber Signature Date

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