BioTek reMEDys®

SKYRIZI™

Please Fax Completed Form To: 800-783-9146

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ L40.0 Plaque Psoriasis (Ps) ☐ L40.52 Psoriatic Arthritis Mutilans ☐ K50.90 Crohn's Disease ☐ Other Diagnosis/ICD-10 Code: _____

TB Test (Date): _____/_____/_____ Results: ☐ Positive ☐ 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
☐ Skyrizi™ (risankizumabrzaa)	☐ Loading dose: 600mg/10mL vial ☐ Infuse 600mg IV at weeks 0, 4 and 8 ☐ Other: _____ ☐ Patient does not need loading dose ☐ Maintenance dose: 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI) ☐ Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter ☐ Other: _____	Refills: _____
☐ Skyrizi™ (risankizumabrzaa) – Psoriasis Indicated	☐ 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 ☐ Other: _____	Refills: _____

Special Instructions: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature