



**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)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

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

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	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
<input type="checkbox"/> Skyrizi™ (risankizumabrzaa)	<input type="checkbox"/> Loading dose: 600mg/10mL vial <input type="checkbox"/> Infuse 600mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI) <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____	Refills: _____
<input type="checkbox"/> Skyrizi™ (risankizumabrzaa) – Psoriasis Indicated	<input type="checkbox"/> 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 <input type="checkbox"/> Other: _____	Refills: _____

Special Instructions: \_\_\_\_\_

**SIGNATURE**

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Prescriber Signature

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