

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Baseline liver function tests (if available)

PRIMARY DIAGNOSIS

- | | | |
|--|---|---|
| <input type="checkbox"/> K50.00 Crohn's disease of small intestine without complications | <input type="checkbox"/> K50.119 Crohn's disease of large intestine with unspecified comps | <input type="checkbox"/> K50.90 Crohn's disease, without complication |
| <input type="checkbox"/> K50.019 Crohn's disease of small intestine with unspecified comps | <input type="checkbox"/> K50.80 Crohn's disease of both small and large int without complications | <input type="checkbox"/> K50.919 Crohn's disease, unspecified, with unspecified comps |
| <input type="checkbox"/> K50.10 Crohn's disease of large intestine without complications | <input type="checkbox"/> K50.819 Crohn's disease of both small and large int with unspecified complications | <input type="checkbox"/> Other: _____ |

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Skyrizi
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Induction Doses (to be administered in infusion clinic):
- Skyrizi 600mg IV at weeks 0, 4, and 8.
- Maintenance Doses (to be self-administered by patient):
- Infusion clinic will coordinate initial maintenance dose from Specialty Pharmacy: Skyrizi 360mg SubQ via on-body device at week 12 and every 8 weeks thereafter.
 - Provider's office will coordinate maintenance dose from Specialty Pharmacy.
 - Other: _____
- First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____ Date _____