Hy-Vee health INFUSION CARE

SKYRIZI (RISANKIZUMAB)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Patient Weight: _____ lbs. (required) **Allergies:** _____

Diagnosis: ☐ Crohn's disease ☐ Other _____ **ICD-10 Code:** _____

Therapy Order

Skyrizi:

☐ IV induction dose: 600 mg IV at weeks 0, 4 and 8 ☐ Maintenance dose: 360 mg subcutaneously at week 12, then every 8 weeks thereafter x1 year (to be evaluated by Hy-Vee Health)

Lab Orders: _____

****LFTs and bilirubin should be monitored at baseline, during induction and periodically****

Lab Frequency: ☐ Prior to 4 and 8 week dose ☐ Other: _____

Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider ☐ Home Health

Other orders: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR SKYRIZI THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

☐ Does the patient have a contraindication/intolerance or failed trial to corticosterioids or immunomodulators (i.e., 6-MP, Azathioprine, Budesonide)?

☐ Yes ☐ No

If yes, which drug(s)? _____

☐ Does the patient have a contraindication/intolerance or failed trial to any biologic (i.e., Humira, Remicade, Stelara, Cimzia)?

☐ Yes ☐ No

If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ If applicable – Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting Skyrizi.

☐ **Other medical necessity:** _____

Required Prescreening

☐ **TB screening test completed – attach results**

☐ **Positive** ☐ **Negative**

☐ **Baseline liver function tests and bilirubin – attach results**

If TB results are positive, please provide documentation of treatment or medical clearance, and a negative CXR

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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