Agile Infusion Services LLC
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SKYRIZI ORDER FOR CROHN'S & ULCERATIVE COLITIS

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ **Diagnosis** *These diagnoses are all without complications. For with complications please change last digit from 0 to 1.*

☐ K50.00 Crohn's disease of sm intestine w/o comp
☐ K50.10 Crohn's disease of lg intestine w/o comp
☐ K50.80 Crohn's disease of both int w/o comp
☐ K50.90 Crohn's disease unspecified w/o comp
☐ K51.00 UC pancolitis w/o comp
☐ K51.20 UC proctitis w/o comp
☐ K51.30 UC rectosigmoiditis w/o comp
☐ K51.50 Left-sided colitis w/o comp
☐ K51.80 Other UC w/o comp
☐ K51.90 UC unspecified w/o comp

■ **Details Needed for Approval** *Please answer all questions and provide supporting documentation.*

Crohn's Disease Induction Therapy:

- Does the patient have active moderate-to-severe Crohn's Disease? _____
- Which conventional agent(s) has the patient tried (and for how long) without effective response? _____
- Which conventional agent(s) has the patient demonstrated an intolerance for (please specify reaction)? _____
- Which conventional agent(s) are contraindicated (please specify contraindication)? _____
- Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas?_____ *If Yes, please attach full details.*
- Has the patient had ileocolonic resection to reduce the change of CD recurrence? _____ *If Yes, please attach full details.*
- Has the patient tried any other biologic immunomodulator for CD? _____ *If Yes, please attach full details.*

Ulcerative Colitis Induction Therapy:

- Does the patient have active moderate-to-severe Ulcerative Colitis? _____
- Which conventional agent(s) has the patient tried (and for how long) without effective response? _____
- Which conventional agent(s) has the patient demonstrated an intolerance for (please specify reaction)? _____
- Which conventional agent(s) are contraindicated (please specify contraindication)? _____
- Has the patient tried an antibiotic, probiotic, corticosteroid enema or mesalamine enema? _____ *If Yes, please attach full details.*
- Will the patient be concurrently treated with another targeted immunomodulator? _____ *If Yes, please attach full details.*
- Does the patient have pouchitis? _____

■ **Medication Order**

☐ Skyrizi (Risankizumab-rzaa) 600mg by IV over at least 1 hours every four (4) weeks for three (3) infusions.
☐ Skyrizi (Risankizumab-rzaa) 1,200mg by IV over at least 2 hours every four (4) weeks for three (3) infusions.

Medication shall be added to a 5% Dextrose or 0.9% NaCl infusion bag; 250ml for 600mg, 250-500mg for 1,200mg. Do not shake the bag. Allow the bag to come to room temperature. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in Case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.