



1935 W. State Street STE 103  
 Garland, TX 75042  
 Ph: 972-372-9787  
 Fx: 972-787-1492

## SKYRIZI INFUSION ORDER FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight =          kg; Height          inches

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Chron's Disease	ICD 10 Code: _____
<input type="checkbox"/> Ulcerative Colitis	ICD 10 Code: _____
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Face sheet and Insurance card <input type="checkbox"/> Clinical/Progress notes	<input type="checkbox"/> Annual TB- Quantiferon TB gold OR neg. chest X-ray <input type="checkbox"/> Labs: CBC w/ diff and LFT's <input type="checkbox"/> Other: _____
List Tried & Failed Therapies, including duration of treatment: <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">             1)              2)              3)           </div> <div style="width: 35%; font-size: small;"> <u>PA Guidance:</u> Failed Steroids, NSAID, MTX, leflunomide. Failed injectable biologics: Humira, Cimzia, Infliximab,           </div> </div>	

ORDERS	
<b>Induction Dose</b> to be mixed in with 0.9% NaCl bag.	<input checked="" type="checkbox"/> (Crohn's) <b>600mg IV</b> at week 0, 4, and 8 THEN <b>180mg subq</b> at week 12, then every 8 weeks. <input type="checkbox"/> (UC) <b>1200mg IV</b> at week 0, 4, and 8 THEN <b>360mg subq</b> at week 12, then every 8 weeks. <input checked="" type="checkbox"/> Normal saline Flushes 10ml as needed (max 10 per infusion) <input type="checkbox"/> PREMEDS: _____
Infusion orders	1. Nurse to start, pause, or discontinue peripheral or central venous access device PRN 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:	NPI #:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to [pharmacy@texasinfusion.com](mailto:pharmacy@texasinfusion.com)

**PLEASE FAX SIGNED FORM TO 972-787-1492**