



A Carelon Company

SKYRIZI (RISANKIZUMAB) ORDER SET

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies: _____

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State: ZIP:
NPI #:	DEA#:	Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Skyrizi IV (risankizumab)	<input type="checkbox"/> 600mg IV at week 0, 4, and 8 <input type="checkbox"/> 1200mg IV at week 0, 4, and 8 <input type="checkbox"/> Other: _____	None
Skyrizi SubQ (risankizumab)	SubQ doses to be evaluated by Paragon Specialty Pharmacy <input type="checkbox"/> 180mg subcutaneously at week 12, then every 8 weeks thereafter <input type="checkbox"/> 360mg subcutaneously at week 12, then every 8 weeks thereafter <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab Orders: _____ Lab frequency: Prior to 4 and 8 week dose Other: _____

LFTs and Bilirubin should be monitored at baseline, during induction, and periodically

Required labs to be drawn by: Paragon Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. 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.

Prescriber Signature: X	Date:
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PATIENT INFORMATION

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 corticosteroids 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 wash-out period of _____ weeks prior to starting Skyrizi.
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- 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