SKYRIZI® (risankizumab-rzaa) Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

Phone: (414) 460-3195
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www.gtinfusions.com

Patient Information

Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code

☐ Primary Diagnosis:	ICD 10 Code:
☐ Secondary Diagnosis:	ICD 10 Code:
☐ Other Diagnosis:	ICD 10 Code:

Supporting Documentation

☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including TB status, baseline liver function. Liver Enzymes and Bilirubin level
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ SKYRIZI® 600 mg IV over 60 minutes at week 0, week 4, and week 8

*Each drug is mixed in 500ml in a 5% dextrose injection and infused over one hour every two weeks. Each infusion flushed with 0.9% sodium chloride upon completion of infusion.

Premedication

☐ Acetaminophen (PO): ☐ 500mg, ☐ 650mg, ☐ 1,000mg **OR** Ibuprofen (PO): ☐ 200mg, ☐ 400mg, ☐ 600mg
☐ Loratadine 10mg (PO) **OR** ☐ Diphenhydramine (PO): ☐ 25mg, ☐ 50mg
☐ Famotidine 20mg (PO) prior to methylprednisolone
☐ Methylprednisolone IV: ☐ 125mg, ☐ 250mg, ☐ 500mg, ☐ 1,000 mg, ☐ Other: _____ mg
☐ Hydrocortisone Sodium Succinate (Solu Cortef) 100 mg IVP
☐ Other (medication, dose, route, and frequency): _____

Labs

☐ CMP – frequency: _____ ☐ BMP – frequency: _____ ☐ HBV – frequency: _____ ☐ HIV – frequency: _____
☐ CBC w/o diff - frequency: _____ ☐ CBC w/diff - frequency: _____ ☐ CBC w/man diff - frequency: _____
☐ Serum Quantitative Immunoglobulins – frequency: _____
☐ Stratify™ JCV Antibody (with Index) with Reflex to Inhibition Assay – frequency: _____
☐ Urine pregnancy test prior to each infusion
☐ Other labs (e.g. thyroid, Blood Glucose) and frequency: _____

Notes (Additional Info)

Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.