Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD Skyrizi® (Risankizumab-rzaa) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive Skyrizi® (risankizumab) if receiving antibiotics for active infectious process, antifungal infection, active fever and/or suspected infection.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: □ L40.0 Psoriasis Vulgaris

□ Other ICD-10_____Diagnosis description: _____

4. Dose/Frequency:

□ Skyrizi 150mg administered subcutaneously at week 0, week 4, and every 12 weeks thereafter.

Maintenance Dosing Only:

□ Skyrizi 150 mg subcutaneously every 12 weeks

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____Date: _____

No Stamp Signatures (Dispense as written) Substitution permitted)

Printed Physician's Name with Credentials:_____NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 6/10/19

Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

Guidelines for Prescribing Skyrizi ® (risankizumab-rzaa) for Dermatology

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-5)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- Skyrizi ® is indicated for **the treatment of moderate-to-severe plaque psoriasis** in adults who are candidates for systemic or phototherapy.

___ Other as requested: _____

_____

Pre-Screening:

___ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

____ Vaccinations: Live vaccines should be avoided during treatment with Skyrizi.

Product information suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.

**Warning/Precautions: Infections: SKYRIZI may increase the risk of infection. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If such an infection develops, do not administer SKYRIZI until the infection resolves. • Tuberculosis (TB): Evaluate for TB prior to initiating treatment with SKYRIZI. See full prescribing information

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 6/10/2019