MRN:_____

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: _____

MRN:_____

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**.

☐ 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

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.