SKYRIZI (risankizumab) Referral Order Form

PACE HEALTHCARE LLC
WWW.PACEINFUSION.COM
PH: 330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits verification only ☐ D/C Infusion **Indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name:_____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____ Contact Fax # _____

NPI / TIN: _____

MEDICATION ORDERS

☐Dose: Skyrizi 600mg IV at weeks 0, 4, and 8

Maintenance Doses (to be self-administered by patient)

☐Pace will coordinate initial maintenance dose from Specialty Pharmacy: Skyrizi 360mg SubQ via on-body device at week 12 and every 8 weeks thereafter

☐Providers Office will coordinate maintenance dose from Specialty Pharmacy

DIAGNOSIS/INDICATION

☐K50.00 Crohn's disease of small intestine without complications
☐K50.019 Crohn's disease of small intestine with unspecified comps
☐K50.10 Crohn's disease of large intestine without complications
☐K50.119 Crohn's disease of large intestine with unspecified comps
☐K50.80 Crohn's disease of both small and large int without complications
☐K50.819 Crohn's disease of both small and large int with unspecified complications
☐K50.90 Crohn's disease, without complication
☐K50.919 Crohn's disease, unspecified, with unspecified comps
☐Other: _____

***icd-10 _____ required**

_____ _____
Referring Physician Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐Current Medication List ☐ History and Physical Report
☐Lab Results ☐ Insurance Cards (front and back) ☐Demographic Sheet

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY