

SKYRIZI (risankizumab) Referral Order Form



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: _____

SKYRIZI MEDICATION ORDERS

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

For free drug, prescribers office will coordinate maintenance ordering and delivery of Skyrizi 360mg sub on-body device.

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

NOTES (ADDITIONAL INFO)

Referring Physician Signature

Date

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