

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: _____

MEDICATION ORDERS

☐ Dose: Dose: Skyrizi 1200 mg IV at weeks 0, 4, and 8 Ulcerative Colitis

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

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

☐ Crohn's disease ()

☐ Ulcerative Colitis ()

☐ Other: _____

NOTES (ADDITIONAL INFO)

*icd-10 _____ required

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