



| PATIENT INFORMATION (Complete or Fax Existing Chart) | PRESCRIBER INFORMATION |
|---|------------------------------------|
| Name: _____ DOB: _____ | Prescriber Name: _____ |
| Address: _____ | State License: _____ |
| City, State, Zip: _____ | NPI #: _____ Tax ID: _____ |
| Phone: _____ Alt. Phone: _____ | Address: _____ |
| Email: _____ SS#: _____ | City, State, Zip: _____ |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ | Phone: _____ Fax: _____ |
| Allergies: _____ | Office Contact: _____ Phone: _____ |

| INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back) | |
|--|--|
| Primary Insurance: _____ | Secondary Insurance (If Applicable): _____ |
| Plan #: _____ | Plan #: _____ |
| Group #: _____ | Group #: _____ |
| RX Card (PBM): _____ | RX Card (PBM): _____ |
| BIN: _____ PCN: _____ | BIN: _____ PCN: _____ |

| CLINICAL INFORMATION |
|--|
| <input type="checkbox"/> L40.0 Plaque Psoriasis (Ps) <input type="checkbox"/> L40.52 Psoriatic Arthritis Mutilans <input type="checkbox"/> K50.90 Crohn's Disease <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other Diagnosis/ICD-10 Code: _____ TB Test (Date): ____/____/____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Lab Orders: _____ Frequency: _____ |

| SKYRIZI™ ORDERS | | |
|--|---|----------------|
| Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____ | | |
| Medication | Dose/Frequency | Refills |
| <input type="checkbox"/> Skyrizi™ (risankizumab) – Chron's Disease Indicated | <input type="checkbox"/> Loading dose: 600mg/10mL vial <input type="checkbox"/> Infuse 600mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____ | Refills: _____ |
| <input type="checkbox"/> Skyrizi™ (risankizumab) – Psoriasis Indicated | <input type="checkbox"/> 150 mg (via one 150 mg injection or two 75 mg injections) subcutaneously at week 0 and week 4, followed by 150 mg subcutaneously every 12 weeks <input type="checkbox"/> Other: _____ | Refills: _____ |
| <input type="checkbox"/> Skyrizi™ (risankizumab) – Ulcerative Colitis Indicated | <input type="checkbox"/> Loading Dose: 600mg/10mL vial <input type="checkbox"/> 1200mg IV on week 0, 4, 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____ | Refills: _____ |

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| Pre-Medication | Dose/Strength | Directions |
|---|--|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> 500mg | <input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed |
| <input type="checkbox"/> Diphenhydramine | <input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO | <input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed |
| <input type="checkbox"/> Methylprednisolone | <input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg | <input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion |
| <input type="checkbox"/> _____ | _____ | _____ |

INFUSION REACTION ORDERS

Mild reaction protocol:

- Diphenhydramine 25mg IV, one time, for pruritus.
- If symptoms worsen, see orders for moderate to severe reactions.*

Moderate reaction protocol:

- Acetaminophen 650mg PO, one time, for pyrexia or rigors
- Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- Famotidine 20mg IV, one time, for pruritus or urticaria
- Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms
- If symptoms worsen, see interventions for severe reactions*

Severe reaction protocol: (Call 911 if initiated):

- Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- Epinephrine 0.3mg/0.3mL IM into mid-antrolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

- 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

- 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

- Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

- Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

- Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____
Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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