Risankizumab-rzaa (Skyrizi IV)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy - Last Treatment Date:		Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Crohn's Disease	ICD-10 Code: K50.90		
☐ Other Diagnosis:	ICD-10 Code:		

REQUIRED DOCUMENTATION/Testing

☐ This signed order form by the provider	☐ Confirmed negative TB testing
☐ Patient demographics AND insurance info	☐ LFT and Bilirubin lab results
☐ Clinical/Progress notes supporting primary dx	

List Tried & Failed Therapies, including duration of treatment:

1) 2)

MEDICATION ORDERS

☐ Skyrizi 600 mg IV at weeks 0 , 4 , 8

SPECIAL INSTRUCTIONS

***Hepatotoxicity in treatment of Crohn's disease. Drug induced liver injury during induction has been reported. Monitor LFT's and bilirubin at baseline and during induction, up to at least 12 weeks of treatment. Monitor thereafter according to routine patient management.*

Provider Name (Print) ****Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 1/27/23