Please fax all pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Skyrizi® (risankizumab-rzaa)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name ______ Last name ______ Middle initial ______

Preferred patient first name ______ Preferred patient last name ______

Sex at birth: Male Female Gender identity ______ Pronouns ______ Last 4 digits of SSN ______

Date of birth ______ Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ Email address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ Email address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ Email address ______

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact email ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ Email ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ______ Has the patient been treated previously for this condition? Yes No

Is patient currently on therapy? Yes No Please list all therapies tried/failed: ______

Patient wt ______ Date wt obtained ______

NKDA Known drug allergies ______

Concurrent meds ______

Patient's first name ______________ Last name ______________ Middle initial _____ Date of birth ____________

Prescriber's first name ______________ Last name ______________ Phone ______________

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Skyrizi® (risankizumab-rzaa)	**Crohn's**		
	Starter dose: 600mg/10mL vial	Infuse 600mg IV at weeks 0, 4 and 8 Patient does not need loading dose If patient needs partial loading dose, indicate what is needed: Week 4 and week 8 Week 8 only	1 vial Refills ______ (Max. 2)
	Maintenance dose: 180mg/1.2mL prefilled cartridge with On-Body Injector (OBI) 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI)	Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter Use the lowest effective dosage to maintain therapeutic response.	1 box (1 pre-filled cartridge + 1 OBI) Refills ______
	--OR--		
	Ulcerative Colitis		
	Starter dose: 600mg/10mL vial	Infuse 1200mg IV at weeks 0, 4 and 8 Patient does not need loading dose If patient needs partial loading dose, indicate what is needed: Week 4 and week 8 Week 8 only	2 vials Refills ______ (Max. 2)
	Maintenance dose: 180mg/1.2mL prefilled cartridge with On-Body Injector (OBI) 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI)	Inject 180mg subcutaneously on week 12 and every 8 weeks thereafter Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter Use the lowest effective dosage to maintain therapeutic response.	1 box (1 pre-filled cartridge + 1 OBI) Refills ______

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

Date ______ **Dispense as written** ______ **Date** ______ **Substitution allowed** ______

If NP or PA, under direction of Dr. ______________ License #: ______________ | If NP or PA, under direction of Dr. ______________ License #: ______________

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Patient's first name ______________ Last name ______________ Middle initial ____ Date of birth __________

Prescriber's first name ______________ Last name ______________ Phone ______________

4 Prescribing Information

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders

Acetaminophen 650mg PO 30 min prior to infusion Diphenhydramine 50mg PO 30 min prior to infusion

Other ________________________________

Send quantity and refills sufficient for medication days supply

Infusion method: Gravity

Fluids for administration and reconstitution (please strike through if not required)

Fluid options should be as follows:

Dilution: NS 0.9% 100mL for Crohn's or 250mL for Ulcerative Colitis

NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: Peripheral access Central venous access

If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion Follow with heparin 100units/mL 5mL final flush

If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis: Stop infusion

Medicate with:

Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

Start NS 0.9% 100mL at TKO Hydrocortisone 100mg slow IVP PRN anaphylaxis

Methylprednisolone 125mg slow IVP PRN anaphylaxis Diphenhydramine 50mg slow IVP PRN anaphylaxis

Diphenhydramine 50mg PO PRN anaphylaxis

Other ________________________________

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.
*If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Lab orders ________________________________

Frequency ________________________________

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

__________	______________________	__________	______________________
Date	**Dispense as written**	**Date**	**Substitution allowed**

If NP or PA, under direction of Dr. ____________ License #: __________ | If NP or PA, under direction of Dr. ____________ License #: __________

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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