Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Skyrizi® (risankizumab-rzaa) for Inflammatory Bowel Disease

EVERNORTH HEALTH SERVICES

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 _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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) for Inflammatory Bowel Disease	**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 _____

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 _____

Send quantity and refills sufficient for medication days supply

☐ 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.

EVERNORTH HEALTH SERVICES

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2026 Evernorth Health Services. All rights reserved. CRO-00005-012626 CRP1582701