Please fax both 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.

Prescription & Enrollment Form

Skyrizi™ (risankizumabrzaa)

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 ______

Sex at birth: Male Female Preferred pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ E-mail address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ E-mail address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ E-mail 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 e-mail ______

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 ______ E-mail ______

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

INFUSION LOCATION: Patient's home Healthcare facility

Medication	Dose	Directions	Quantity/Refills
Skyrizi™ (risankizumabrzaa)	Loading 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)
	Maintenace dose: 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI)	Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter	1 box (1 pre-filled cartridge + 1 OBI) Refills ________

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

Send quantity and refills sufficient for medication days supply

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: Dextrose 5% 100mL

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

Methylprednsiolone 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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