PREMIER VITALITY

Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

SKYRIZI ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies:

_____ Height:

_____ Weight: _____

Indication:

☐ K50.____ Crohn's Disease

☐ Other _____

DRUG:

☐ 600mg IV at weeks 0, 4 and 8

☐ Other

_____

PREMEDICATION ORDERS: *not required by PI*

☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.

☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion.

☐ Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other_____ 30 min prior to infusion.

☐ Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive <u>ALL</u> the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: _____