



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart) PRESCRIBER INFORMATION					
•	<u> </u>				
	DOB:		Prescriber Name: State License:		
		NDI #. Toy ID.			
,	Alt. Phone:				
	SS#:				
	(lbs) Ht:				
Allergies:		Office Contact:			
INSURANCE INFORMATION	– AND – Send a copy of the	patient's prescription/insurance cards (fro	nt & back)		
Primary Insurance:	Primary Insurance:		Secondary Insurance (If Applicable):		
	PCN:				
CLINICAL INFORMATION					
☐ L40.0 Plague Psoriasis (Ps) ☐	□ L40.0 Plaque Psoriasis (Ps) □ L40.52 Psoriatic Arthritis Mutilans □ K50.90 Crohn's Disease □ Other Diagnosis/ICD-10 Code:				
TB Test (Date):/ Results: Positive Negative					
Lab Orders: Frequency:					
SKYRIZI™ ORDERS					
	☐ Destant ☐ Continued themse.	Total Dagge Dagging d. Date of Leatin	instinu (Informinu)		
Prescription type: New start	☐ Restart ☐ Continued therapy	Total Doses Received: Date of Last In	1		
		Dose/Frequency	jection/Infusion: Refills		
Prescription type: New start	☐ Loading dose: 600mg/10mL v	Dose/Frequency ial	1		
Prescription type: New start	☐ Loading dose: 600mg/10mL v	Dose/Frequency ial 0, 4 and 8	1		
Prescription type: New start Medication	☐ Loading dose: 600mg/10mL v ☐ Infuse 600mg IV at weeks ☐ Other:	Dose/Frequency ial 0, 4 and 8	Refills		
Prescription type: New start	☐ Loading dose: 600mg/10mL v ☐ Infuse 600mg IV at weeks ☐ Other: ☐ Patient does not need load	Dose/Frequency ial 0, 4 and 8 ding dose	1		
Prescription type: New start Medication	☐ Loading dose: 600mg/10mL v ☐ Infuse 600mg IV at weeks ☐ Other: ☐ Patient does not need load ☐ Maintenance dose: 360mg/2.4	ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI)	Refills		
Prescription type: New start Medication	☐ Loading dose: 600mg/10mL v ☐ Infuse 600mg IV at weeks ☐ Other: ☐ Patient does not need load ☐ Maintenance dose: 360mg/2.4 ☐ Inject 360mg subcutaneou	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter	Refills		
Prescription type: New start Medication	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other:	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter	Refills		
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Prescription type: ☐ New start ☐ Medication ☐ Skyrizi™ (risankizumabrzaa)	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter	Refills		
Prescription type: ☐ New start ☐ Medication ☐ Skyrizi™ (risankizumabrzaa) ☐ Skyrizi™ (risankizumabrzaa) — Psoriasis Indicated	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at	Refills Refills:		
Prescription type: ☐ New start ☐ Medication ☐ Skyrizi™ (risankizumabrzaa) ☐ Skyrizi™ (risankizumabrzaa) — Psoriasis Indicated Special Instructions:	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by 3	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at 150 mg subcutaneously every 12 weeks	Refills Refills:		
Prescription type: ☐ New start ☐ Medication ☐ Skyrizi™ (risankizumabrzaa) ☐ Skyrizi™ (risankizumabrzaa) — Psoriasis Indicated Special Instructions: Pre-Medication	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by 30 other: □ Other:	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at 150 mg subcutaneously every 12 weeks Directions	Refills:		
Prescription type: ☐ New start ☐ Medication ☐ Skyrizi™ (risankizumabrzaa) ☐ Skyrizi™ (risankizumabrzaa) — Psoriasis Indicated Special Instructions:	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by 30 □ Other: □ Dose/Strength □ 500mg	Dose/Frequency ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at 150 mg subcutaneously every 12 weeks Directions Take 1-2 tablets PO prior to infusion or post-infus	Refills: Refills: ion as directed		
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Prescription type: □ New start □ Medication □ Skyrizi™ (risankizumabrzaa) □ Skyrizi™ (risankizumabrzaa) − Psoriasis Indicated Special Instructions: □ Pre-Medication □ Acetaminophen	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by 3000 other: □ Other: □ Dose/Strength □ 500mg □ 25mg IV/PO □ 50mg IV/PO	ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at 150 mg subcutaneously every 12 weeks Directions Take 1-2 tablets PO prior to infusion or post-infus Take 1 tablet PO prior to infusion or as directed C Inject contents of 1 vial IV prior to infusion or as designed.	Refills: Refills: ion as directed Refills:		
Prescription type: □ New start □ Medication □ Skyrizi™ (risankizumabrzaa) □ Skyrizi™ (risankizumabrzaa) − Psoriasis Indicated Special Instructions: □ Pre-Medication □ Acetaminophen □ Diphenhydramine	□ Loading dose: 600mg/10mL v □ Infuse 600mg IV at weeks □ Other: □ Patient does not need load □ Maintenance dose: 360mg/2.4 □ Inject 360mg subcutaneou □ Other: □ 150 mg (via one 150 mg inject week 0 and week 4, followed by 30 mg of the second by 30 mg	ial 0, 4 and 8 ding dose 4mL prefilled cartridge with On-Body Injector (OBI) usly on week 12 and every 8 weeks thereafter ion or two 75 mg injections) subcutaneously at 150 mg subcutaneously every 12 weeks Directions Take 1-2 tablets PO prior to infusion or post-infus Inject contents of 1 vial IV prior to infusion or as of	Refills: Refills: ion as directed R lirected		
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medicine as prescribed in this referral.

Prescriber Signature



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

Date: ____

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INFUSION REACTION ORDERS						
Mild reaction protocol:						
☑ Diphenhydramine 25mg IV, one time, for pruritus.						
If symptoms worsen, see orders for moderate to see	If symptoms worsen, see orders for moderate to severe reactions.					
Moderate reaction protocol:						
☐ Acetaminophen 650mg PO, one time, for pyrexia or rigors						
☑ Diphenhydramine 50mg IV, one time, for pruritus or urticaria						
☑ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms						
If symptoms worsen, see interventions for severe reactions						
Severe reaction protocol: (Call 911 if initiated):						
☑ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)						
☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis						
☑ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis						
☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms						
☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or						
worsen						
FLUSHING & LOCKING ORDERS						
Flushing Protocol (>66lbs/33kg)						
PIV and Midline:		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:				
\boxtimes 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion		☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL				
		IV flush after infusion/lab draw				
Locking Protocol (>66lbs/33kg)						
PIV and Midline:	PICC:		Implanted Port, Tunneled Catheter, and Non-			
☐ Heparin Sodium 10 units/mL 1mL IV final			tunneled Catheter:			
flush post normal saline flush			☐ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush			
** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused						
SIGNATURE						
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the						

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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