LivWell INFUSIONS

Skyrizi Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ K50.0 Crohn's disease of small intestine
- ◯ K50.1 Crohn's disease of large intestine
- ◯ K50.8 Crohn's disease of both small and large intestine
- ◯ K50.9 Crohn's disease, unspecified
- ◯ K51.90 Ulcerative colitis, unspecified, without complications

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

SKYRIZI ORDER

Initial Skyrizi Dose:
To be administered Week 0, Week 4, and Week 8.

Initial IV ◯ 600 mgIV ◯ 1200mgIV

Maintenance Skyrizi Dose via OBI:
To be administered at home.

SubQ injection ◯ 360 mg every 8 weeks

Premeds:

- ☐ Benadryl (Diphenhydramine) ◯ Oral 25mg ◯ Oral 50mg ◯ IV 50mg
- ☐ Acetaminophen (Tylenol) ◯ 325 mg ◯ 650 mg

Additional Comments:

Date of last Skyrizi Injection: _____

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____