



For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

Name: DOB:
Phone: Other Phone:
Email:
Social Security #: Allergies:
Gender: M F Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name: NPI#:
License #: TIN#: DEA#:
Address:
City: State Zip
Office Contact: Email:
Office phone: Office fax:

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

Crohn's Disease () Ulcerative Colitis () Other: *Labs: TB, Baseline Liver Enzymes and Bilirubin required prior to initial infusion*

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

SKYRIZI PRE-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Loading Dose: Administer 600mg IV at week 0, week 4, and week 8
Administer 1200mg IV at week 0, week 4, and week 8
Vital signs per HI Protocol
Anaphylaxis & Hydration Management per HI Protocol
POST-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Prednisone mg PO
Other

6. LABS

CBC w/Diff Each Infusion Other Frequency (specify):
CRP Each Infusion Other Frequency (specify):
CMP Each Infusion Other Frequency (specify):
ESR Each Infusion Other Frequency (specify):
Hepatic Panel Each Infusion Other Frequency (specify):
Renal Panel Each Infusion Other Frequency (specify):
Quantiferon TB Gold, annually, last completed (date):
Other (specify):

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE