Skyrizi

UHO
Upstate Hematology Oncology
at Community Care Physicians

Ph: 518-836-3030 | Fax: 518-836-3020

Date: _____

Please include the following to expedite the order	**Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Viral Hepatitis Results, TB Results**

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs ○ kg Height: _____

Diagnosis: _____

ICD 10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

○ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

PREMEDS

○ No Premeds

Benadryl:	○ PO ○ IV	○ 25 mg ○ 50 mg
Acetaminophen:	○ PO	○ 650 mg ○ Other: _____
Methylprednisolone:	○ IV	○ _____ mg

Other: _____

○ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: _____ Date: _____

SKYRIZI DOSAGE

Date of Last Treatment, if Continuation: _____

Route: IV

○ For Crohn's Disease

Dose: 600 mg IV infusion over 1 hour

○ For Ulcerative Colitis

Dose: 1200 mg IV infusion over 2 hours

Frequency: Induction dose at 0, 4, and 8 weeks

(if not indicated order will expire 6 months from date signed)

To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.

LAB ORDERS

○ No Labs

List: _____ Frequency: _____

Signature: _____ Date: _____