January 2026

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

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:
☐ K50.90 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other

DRUG:
☐ Induction 600mg IV at weeks 0, 4 and 8 - Crohn's
☐ Induction 1200 mg IV at weeks 0, 4, and 8 - UC
☐ Maintenance 180mg or 360 mg subcutaneous week 12 and every 8 weeks thereafter - Crohn's and UC
☐ Other

PREMEDICATION ORDERS:

☐ Acetaminophen:	☐ 1000mg PO ☐500mg PO	30 min prior to infusion.
☐ Diphenhydramine:	☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP	30 min prior to infusion.
☐ Methylprednisolone:	☐ 62.5mg IVP ☐ 125mg 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 ALL 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: ____
☐ Bilirubin