Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

SKYRIZI FOR CROHN'S DISEASE MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ Diagnosis

Please provide diagnosis and code to the highest possible level of specificity.

☐ K50.0____ Crohn's disease of small intestine
☐ K50.1____ Crohn's disease of large intestine
☐ K50.8____ Crohn's disease of both sm and lg intestine
☐ K50.9____ Crohn's disease unspecified

■ Details Needed for Authorization

Please send documentation, chart notes and results which support these answers.

- Does the patient have active moderate-to-severe Crohn's Disease? _____
- Which conventional agent(s) has the patient tried (and for how long) without effective response? _____
- Which conventional agent(s) has the patient demonstrated an intolerance for (please specific reaction)? _____
- Which conventional agent(s) are contraindicated (please specify contraindication)? _____
- Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas?_____ If Yes, please attach full details.
- Has the patient had ileocolonic reseaction to reduce the change of CD recurrence?_____ If Yes, please attach full details.
- Has the patient tried any other biologic immunomodulator for CD? _____ If Yes, please attach full details.

■ Medication Order

Patient's height in feet/inches: _____ **Patient's weight in pounds: _____**

☐ Skyrizi (Risankizumab-rzaa) 600mg by IV every 4 weeks for three (3) infusions.

Medication shall be added to a 250ml 5% Dextrose infusion bag. Do not shake the bag. Allow the bag to come to room temperature. Infuse over at least 1 hour. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

Note: Only IV starter doses are available at Beacon Infusion. Continuing therapy with On-Body Injector is not available at Beacon Infusion.

■ Rescue Management in case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.