PRIMERA SPECIALTY INFUSION

PHONE 689-303-3338

FAX 689-303-3240

795 PRIMERA BLVD, SUITE 1011

LAKE MARY, FL 32746

SKYRIZI REFERRAL FORM
CROHN'S DISEASE

PATIENT INFORMATION

Patient Name ______________________

Date of Birth ________ Gender ○ Male ○ Female

Alternate Contact Number ________________

Address ____________________

City ________________

Zip Code ____________

Phone Number ________________

Email ______________________

PRESCRIBER INFORMATION

Prescriber Name ______________________

NPI # __________ DEA # ________

State Lic # __________ UPI # ________

Practice Name ______________________

Adress ______________________

City, State, Zip ______________________

Office Contact ______________________

Office Contact Email ______________________

CLINICAL INFORMATION

Primary Diagnosis/ICD10 ________________ Diagnosis Date ______ Height ______ Weight ______

Access Type: ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman

Negative TB Test: ☐ Yes ☐ No Date of Test: ________ Last Infusion Date ____________

Prior Therapy/Dates of Use ________________ Next Infusion Date ____________

Allergies: ______________

PRESCRIPTION INFORMATION

Medication Name:	**Skyrizi®**
Directions	Dose: __________ mg/kg Total dose: **600mg** Quantity: __ Refills: **0** Directions: **Skyrizi 600mg IV on week 0, 4, and 8** Administration Rate: ☐ Per Prescribing Information, as tolerated ☐ Other: ______________________
Pre-Medications	☐ Acetaminophen _______mg 30 minutes prior to infusion PO ☐ Diphenhydramine _______mg 30 minutes prior to infusion ☐ PO ☐ IV ☐ Solu-Cortef _______mg slow IVP ☐ Solu-Medrol _________mg slow IVP Administered: ☐ Pre ☐ Halfway ☐ Upon Completion
Pump and Ancillary Supplies	☐Pump and supplies as needed for administration and appropriate disposal of infusion materials Infliximab doses will be rounded to the nearest 100mg vial unless this box is checked
Skilled Nursing Visits	☐ As needed for IV access, administration and appropriate clinical monitoring

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Harper Health LLC d/b/a Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion.

Prescriber Signature ______________________ Date ________