



PRIMERA SPECIALTY INFUSION

PHONE 689-303-3338

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795 PRIMERA BLVD, SUITE 1011

LAKE MARY, FL 32746

SKYRIZI REFERRAL FORM ULCERATIVE COLITIS

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 _____
 Address _____
 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: 1,200mg Quantity: __ Refills: 0 Directions: Skyrizi 1200mg IV on week 0, 4, and 8 Administration Rate: <input type="checkbox"/> Per Prescribing Information, as tolerated <input type="checkbox"/> Other: _____
Pre-Medications	<input type="checkbox"/> Acetaminophen _____ mg 30 minutes prior to infusion PO <input type="checkbox"/> Diphenhydramine _____ mg 30 minutes prior to infusion <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Solu-Cortef _____ mg slow IVP <input type="checkbox"/> Solu-Medrol _____ mg slow IVP Administered: <input type="checkbox"/> Pre <input type="checkbox"/> Halfway <input type="checkbox"/> Upon Completion
Pump and Ancillary Supplies	<input type="checkbox"/> Pump and supplies as needed for administration and appropriate disposal of infusion materials Infiximab doses will be rounded to the nearest 100mg vial unless this box is checked
Skilled Nursing Visits	<input type="checkbox"/> 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 _____