



PRIMERA SPECIALTY INFUSION

SKYRIZI REFERRAL FORM

Patient Name _____
Date of Birth _____
Gender at Birth ☐ Male ☐ Female
Address _____
City, State, Zip _____
Phone _____
Email _____
Primary Insurance _____
Secondary Insurance _____

Prescriber Name _____
NPI # _____ **DEA #** _____
State Lic # _____ **UPI #** _____
Practice Name _____
Address _____
City, State, Zip _____
Office Contact _____
Office Contact Phone _____
Office Contact Email _____

CLINICAL INFORMATION

Primary Diagnosis/ICD10 _____ **Current Therapy** _____
Diagnosis Date _____ **Current Directions** _____
Prior Therapies/Duration of Use _____
Access Type ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman **Last Dose** _____ **Next Dose** _____
Negative HBV ☐ Yes ☐ No **Date of Test:** _____ **Weight** _____ **Height** _____
Negative TB ☐ Yes ☐ No **Date of Test:** _____ **Allergies** _____

PRESCRIPTION INFORMATION

Medication	Skyrizi®
Directions	☐ Crohn's Loading Dose: 600 mg Total dose: 600 mg Quantity: 1 Refills: 2 Directions: Skyrizi 600 mg IV on week 0, 4, and 8 Administration Rate: ☒ Per Prescribing Information, as tolerated ☐ Other: _____ ☐ UC Loading Dose: 1,200 mg Total dose: 1,200 mg Quantity: 1 Refills: 2 Directions: Skyrizi 1200 mg IV on week 0, 4, and 8 Administration Rate: ☒ Per Prescribing Information, as tolerated ☐ Other: _____
Pre-Medications	☒ Acetaminophen 650mg 30 minutes prior to infusion PO ☒ Diphenhydramine 25mg 30 minutes prior to infusion ☐ PO ☐ IV ☐ Solu-Cortef _____ mg slow IVP ☐ Solu-Medrol _____ mg slow IVP Administered: ☒ Pre ☐ Halfway ☐ Upon Completion
Anaphylaxis Orders and Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt. <15kg), Administer 25mg (wt. 15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL - Administer _____ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% - Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	☒ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin _____ Units/mL _____ mL as needed
Pump and Ancillary Supplies	☒ Pump and supplies as needed for administration and appropriate disposal of infusion materials
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 handwritten "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 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.

Phone (689) 303-3338 Fax (689) 303-3240 Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746

Prescriber Signature _____

Date _____