BluHaven HEALTH

Skyrizi Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List
Tried and Failed Therapies (including duration) | Negative TB Results | Baseline Liver Function Tests (if available)

Primary Diagnosis

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.019 Crohn's disease of small intestine with unspecified comps
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.119 Crohn's disease of large intestine with unspecified comps
☐ K50.80 Crohn's disease of both small and large int without complications
☐ K50.819 Crohn's disease of both small and large int w/unsp comp
☐ K50.90 Crohn's disease, without complication
☐ K50.919 Crohn's disease, unspecified, with unspecified comps
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
☐ K51.019 Ulcerative (chronic) pancolitis with unsp complications
☐ K51.80 Other ulcerative colitis without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Skyrizi
☐ Provider Prescribed: _____

Primary Medication Order

Induction (To be administered in infusion clinic.):
☐ Crohn's: Skyrizi 600mg IV at weeks 0, 4, and 8
☐ UC: Skyrizi 1200mg IV at weeks 0, 4, and 8

Maintenance (To be administered in infusion clinic.):
☐ Skyrizi 180mg subQ via on-body device at week 12 and every 8 weeks thereafter
☐ Skyrizi 360mg subQ via on-body device at week 12 and every 8 weeks thereafter

☐ Provider's Office will coordinate maintenance dose from Specialty Pharmacy
☐ Other: _____
First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC
☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*