TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

SKYRIZI™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ L40.0 Plaque Psoriasis (Ps) ☐ L40.52 Psoriatic Arthritis Mutilans ☐ K50.90 Crohn's Disease ☐ Other Diagnosis/ICD-10 Code: _____

TB Test (Date): _____/_____/_____ Results: ☐ Positive ☐ Negative

Lab Orders: _____ Frequency: _____

SKYRIZI™ ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
☐ Skyrizi™ (risankizumabrzaa)	☐ Loading dose: 600mg/10mL vial ☐ Infuse 600mg IV at weeks 0, 4 and 8 ☐ Other: _____ ☐ Patient does not need loading dose ☐ Maintenance dose: 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI) ☐ Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter ☐ Other: _____	Refills: _____
☐ Skyrizi™ (risankizumabrzaa) – Psoriasis Indicated	☐ 150 mg (via one 150 mg injection or two 75 mg injections) subcutaneously at week 0 and week 4, followed by 150 mg subcutaneously every 12 weeks ☐ Other: _____	Refills: _____

Special Instructions: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.