



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

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

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	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
<input type="checkbox"/> Skyrizi™ (risankizumabrzaa)	<input type="checkbox"/> Loading dose: 600mg/10mL vial <input type="checkbox"/> Infuse 600mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient does not need loading dose <input type="checkbox"/> Maintenance dose: 360mg/2.4mL prefilled cartridge with On-Body Injector (OBI) <input type="checkbox"/> Inject 360mg subcutaneously on week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____	Refills: _____
<input type="checkbox"/> Skyrizi™ (risankizumabrzaa) – Psoriasis Indicated	<input type="checkbox"/> 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 <input type="checkbox"/> 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.

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