

Skyrizi INFUSION order



Patient Name

DOB

Phone

M

F

DIAGNOSIS *Please provide ICD-10 code*

K50.00 Chron's disease of small intestine without complications

K50.90 Chron's disease, unspecified

K50.918 Chron's disease, unspecified, with other complication

PRE-MEDICATION

(other)

Skyrizi ORDERS

DOSAGE

600mg intravenous infusion on week 0, 4, 8

600mg intravenous infusion every 4 weeks for maintenance

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Signature **X**

Date

Provider

Phone

Fax