arise infusion
THERAPY SERVICES
A DIVISION OF ARTHRITIS AND RHEUMATISM ASSOCIATES, PC

Fax To: 301-424-3590
Have a Question? Call: 240-514-5000

SKYRIZI (risankizumab-rzaa) ORDER FORM

REFERRAL TYPE

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Frequency Change ☐ Dosage Change

PREFERRED LOCATION

☐ 2730 University Blvd. West | Suite 714 Wheaton, MD 20902	☐ 14995 Shady Grove Road | Suite 250 Rockville, MD 20850	☐ 5454 Wisconsin Avenue | Suite 600 Chevy Chase, MD 20815
☐ 18111 Prince Philip Drive | Suite 323 Olney, MD 20832	☐ 161 Thomas Johnson Drive | Suite 250 Frederick, MD 21702	☐ 2021 K Street, NW | Suite 300 Washington, DC 20006
	☐ 8270 Willow Oaks Corporate Drive | Suite 150 Fairfax, VA 22031	

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: KG LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:		NPI:
Office Contact Name:	Phone:	Fax:
Address:		

SKYRIZI ORDER

WE DO NOT ACCEPT OFF-LABEL DIAGNOSIS, DOSE AND FREQUENCY

Dosing/Frequency:

☐ Initial: 600mg IV at week 0, week 4, and week 8

Diagnosis:

☐ K50.00 - K50.019 Crohn's Disease of small intestine
☐ K50.1 - K50.119 Crohn's Disease of large intestine
☐ K50.8 - K50.819 Crohn's Disease of both small and large intestine

☐ Other Diagnosis: ICD-10 Code (Required):

Special Instructions:

Physicians Signature:	Date: ***(Order is Valid for One Year)***

REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Copy of the patient's insurance card(s) – front and back
- Most recent labs that include values for TB screening (PPD, QFT Gold or TSpot), CMP, CBC, HBV Surface Antigen (HEP B), HCV Antibody
- Medication History
- For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.