InfuCare Rx®

Skyrizi® Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ K50.00 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary: ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Refills:
☐ Skyrizi®	☐ 600mg/10mL vial ☐ 600mg/10mL vial x 2 ☐ 180mg/1.2mL On-Body Injector KIT ☐ 360mg/2.4mL On-Body Injector KIT	☐ **Crohn's Initial:** 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) ☐ **Ulcerative Colitis Initial:** 1200mg administered by IV over at least two hours at week 0, week 4, and week 8 (Quantity: 3) ☐ **Maintenance:** ☐ 180mg or ☐ 360mg SUBQ at week 12 and every 8 weeks thereafter.	

Premedications & Other Medications:
- Infusion supplies as per protocol
- Anaphylaxis Kit as per protocol

☐ Acetaminophen: _____ mg PO prior to infusion
☐ Diphenhydramine: _____ mg ☐ PO ☐ IV
☐ 250ml 0.9% NaCl for hydration
☐ Other: _____

Flush Protocol:
- NaCl 0.9% 10ml
- Before and after infusion

ADDITIONAL COMMENTS

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

Revised 31 Dec 2025