CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

ENTYVIO / SKYRIZI ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	Last 4 of SSN (required):
Date of Birth:	☐ Male or ☐ Female	Height (required): _____ ☐ cm or ☐ inches	Weight (required): _____ ☐ lb or ☐ kg

CLINICAL INFORMATION

Primary ICD-10 Code:	Is patient currently on therapy? ☐ Yes ☐ No	Previous tried/failed therapies:	Allergies:

REQUIRED: Has the patient tested NEGATIVE for TB? ☐ Yes ☐ No ☐ Pending Result:_____ Test Date: _____

RECOMMENDED (ENTYVIO ONLY): Has the patient tested for JCV antibodies? ☐ Yes ☐ No ☐ Pending Result:_____ Test Date: _____

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals and any available lab results.

PRESCRIPTION AND ORDERS

Medication	Dosing		Quantity	Refills
☐ **Entyvio®**	**Induction:** ☐ 300 mg IV at 0, 2 & 6 weeks ☐ Other: _____	**Maintenance:** ☐ 300 mg IV every 8 weeks after induction ☐ Other: _____	☐ 3 doses for induction ☐ 8-week supply for maintenance ☐ Other: _____	x 1 year unless noted otherwise: ☐ ____refills
☐ **Skyrizi®** (Plaque Psoriasis and Psoriatic Arthritis)	**Induction:** ☐ Adults: 150 mg SUBQ at 0 & 4 weeks	**Maintenance:** ☐ Adults: 150 mg SUBQ every 12 weeks ☐ Other: _____	☐ 2 doses for induction, no refills ☐ 12-week supply for maintenance ☐ Other: _____	x 1 year unless noted otherwise: ☐ ____refills
☐ **Skyrizi®** (Crohn's Disease)	**Induction:** ☐ Adults: 600 mg IV at 0, 4 & 8 weeks ☐ Other: _____	**Maintenance:** ☐ Adults: 180 mg SUBQ at week 12, then every 8 weeks ☐ Adults: 360 mg SUBQ at week 12, then every 8 weeks	☐ 3 doses for induction, no refills ☐ 2 doses for first maintenance, then 8 week supply	1 year unless noted otherwise: ☐ ____refills
☐ **Skyrizi®** (Ulcerative Colitis)	**Induction:** ☐ Adults: 1200 mg IV at 0, 4 & 8 weeks ☐ Other: _____	**Maintenance:** ☐ Adults: 180 mg SUBQ at week 12, then every 8 weeks ☐ Adults: 360 mg SUBQ at week 12, then every 8 weeks	☐ 3 doses for induction, no refills ☐ 2 doses for first maintenance, then 8 week supply	1 year unless noted otherwise: ☐ ____refills

PRN: ☐ Diphenhydramine 25-50 mg PO every 6 hours PRN mild-moderate infusion reaction, dispense x 1 bottle (refill x 1 year)

Labs:

Flush Orders (IV infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year).

Supplies: Dispense ancillary supplies, including ambulatory infusion pump (IV infusions ONLY), as needed to provide home infusion therapy.

Adverse/Anaphylactic Reactions, per protocol (Subcutaneous):

- Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x 1 (refill x 1 year)

- Epinephrine 1:1000, 1 mL vial x 1
- Diphenhydramine 50 mg/1 mL vial x 1
- Diphenhydramine 50 mg tab/cap x 1
- 0.9% Sodium Chloride 500 mL bag x 1

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events. Additional teaching visits may be required for self-administration.

PRESCRIBER INFORMATION

Prescriber Name:		Practice site name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	

Office contact and special instructions:

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: **Date:**

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