Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Skyrizi For Crohn's Disease

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856) 770-8271 ~ Attn: Stephanie D

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	❒ Voorhees ❒ Moorestown ❒ Wall/Manasquan ❒ Sewell ❒ Hamilton ❒ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Name (last, first) _____DOB: _____

Diagnosis:
❒ K50.0 Crohn's disease of small intestine
❒ K50.1 Crohn's disease of large intestine
❒ K50.8 Crohn's disease of both small and large intestine
❒ K50.9 Crohn's disease unspecified
❒ Other: _____

The following information is required for authorization for Crohn's disease:

- Does the patient have active moderate-to-severe Crohn's Disease? ❒ YES ❒ NO
- Which conventional agent(s) has the patient tried (and for how long) without effective response?
    - _____
    - _____
    - _____
- Which conventional agent(s) has the patient demonstrated an intolerance for (please specify reaction)?
    - _____
    - _____
    - _____
- Which conventional agent(s) are contraindicated (please specify contraindication)?
    - _____
    - _____
    - _____
- Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ❒ YES ❒ NO
    - If Yes, please attach full details.
- Has the patient had ileocolonic resection? ❒ YES ❒ NO
    - If Yes, please attach full details.

- Has the patient tried any other biologic immunomodulator? ❒ YES ❒ NO
    - If Yes, please attach full details.

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
    - ** NOTE ** Please DO NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- Include recent chart notes, scans, tests, labs to support the start of Skyrizi.
- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if the medication is discontinued.

Ordering Provider Signature: _____