Frontier
INFUSION CENTER®

## Sending a Referral to Frontier Infusion Center

Follow the steps below to send a referral to Frontier Infusion Center:

1. Download the desired order form from our website (www.frontierinfusioncenter.com).
2. Fill out all fillable fields on the digital version **OR** print and fill form out manually.
3. Fax completed order form with all required documentation listed below to **(346) 245-8026**.

## Required Documentation Checklist

If we do not receive all documents below with your referral, the order is subject to delays. **It may take up to 14 business days for the patient's insurance company to approve or deny our authorization request.*

- ☐ Completed Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorization *(if applicable)*

## How to Use Our Digital Order Forms

1. Upon downloading the desired form, you will see light blue text box, check box, and circle box fields appear. To fill out the form on your computer, click into these fields to type out the necessary patient, office, clinical history, and therapy administration information. You can copy/paste information from the patient's medical record into this form.
2. There is a section at the bottom of each fillable form that allows "Additional Notes from Referring Office" to be added. If you are not finding a field to enter information you need to send over, please put it here.
3. Gather the referring provider's signature to approve the order once you have filled out all fields and send to Frontier Infusion Center via fax.

**Phone: (800) 215-3219  Fax: (346) 245-8026**

# Skyrizi (risankizumab-rzaa)

**Order Form**
*Rev.* 2/01/2024

Frontier INFUSION CENTER
**Phone: (800) 215-3219**
**Fax: (346) 245-8026**

**PATIENT INFORMATION** **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to FIC.
The patient has an existing prior authorization: ○ Yes*(please fax FIC a copy)* ○ No *(FIC will process for you)*

**PRESCRIBING OFFICE**

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

**CLINICAL HISTORY**

In the past year, what medications for the above diagnosis has the patient tried and failed?

| Drug & Dose | Dates of Use | Drug & Dose | Dates of Use |
|---|---|---|---|
| | | | |
| | | | |

TB Verification *(check one)*: ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray
Result Date: _____ Result *(check one)*: ○ Positive ○ Negative

**LAB ORDERS**

Collect: ☐ CMP ☐ CBC w/ Diff ☐ CBC w/o Diff ☐ CBC w/ man diff ☐ CRP ☐ ESR ☐ _____
Lab Frequency: ○ EVERY infusion ○ First infusion only ○ _____

**THERAPY ADMINISTRATION**

**Skyrizi (Risankizumab-rzaa) IV:**
Dose: 600 mg
IV induction frequency: Every 4 weeks x 3 doses
Date of last infusion if not at FIC: _____ RX Expiration Date: _____

**Additional Notes from Referring Office:**

**Provider Name (Print)** **Provider Signature** **Date**