Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

01 PATIENT INFORMATION

Patient legal name

Date of birth (MM/DD/YYYY)

Patient phone

Preferred language / interpreter need

Caregiver name / phone (if applicable)

Street address

City

State / ZIP

Diagnosis / ICD-10 code(s)

Weight (kg) / date measured

Height (cm) / date measured

02 COVERAGE INFORMATION

Primary insurance plan

Member ID

Group number

Policyholder name / DOB / relationship

Secondary plan / member ID

Prescription plan / member ID

Rx BIN / PCN / group

03 REFERRING CLINICIAN

Prescriber name / credentials

NPI

Specialty

Practice name / address

Office phone

Office fax

Referral contact / direct phone

Referral date / requested start date

Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

04 THERAPY REQUEST - COMPLETE FROM THE PRESCRIBER'S ORDER

Exact product / brand / formulation

Route / administration setting

Dose and units

Frequency / cycle / duration

Last dose / next dose due

Loading / maintenance instructions, quantity, refills or attached order reference

05 CLINICAL CONTEXT

Requested formulation / route; indication; induction or maintenance treatment dates.

Therapy-specific notes / supporting record references

Allergies / reactions and prior therapy tolerance (or attach record)

Current medications, access / training needs and monitoring orders (or attach record)

06 RECORDS TO INCLUDE, AS APPLICABLE

- [ ] Signed prescription / treatment orders
- [ ] Clinical notes / diagnosis support
- [ ] Prescriber-directed labs / screening
- [ ] Required product / program enrollment
- [ ] Insurance cards (front and back)
- [ ] Current medication and allergy list
- [ ] Prior authorization / payer records
- [ ] Other therapy-specific documentation

Attach signed orders and required product-specific documents. This worksheet does not replace clinical screening.

Prepared by / role / direct phone

Date completed

Risankizumab referral

Risankizumab-rzaa | Autoimmune & GI

Review draft only. Not a standalone prescription or administration protocol.
Secure referral destination is not configured. Do not submit patient information through the website.

Patient legal name

Date of birth (MM/DD/YYYY)

07 COMMON CLINICAL RECORDS FOR PRIOR AUTHORIZATION

Check when attached / reviewed. Items depend on indication and plan. Record N/A or gaps below.

- [ ] Specialist diagnosis, disease activity and exact indication for the requested formulation.
- [ ] GI studies, skin severity / affected areas, or joint findings relevant to the patient's indication.
- [ ] Prior systemic / biologic treatments with dates, response, intolerance or contraindication.
- [ ] Induction and maintenance plan; screening and monitoring documentation required for the indication.
- [ ] Renewal: objective or symptom response, current regimen and explanation of requested changes.

08 AUTHORIZATION AND PAYMENT REVIEW - ADARA / BILLING TEAM

- [ ] Eligibility and benefits verified for the service date; correct medical vs pharmacy benefit, network and site of care.
- [ ] Current plan policy and preferred product checked; required specialty supplier / sourcing and exception approvals confirmed.
- [ ] Written authorization matches product, route, dose, frequency, units, dates and rendering / billing provider identifiers.
- [ ] Contracted payment terms, drug acquisition cost, nursing / supplies and patient responsibility reviewed; assistance eligibility verified.
- [ ] Claim preparation: validate diagnosis, product-specific HCPCS / NDC, unit conversion, service codes and applicable modifiers.
- [ ] Retain signed orders, delivery / administration records and wastage details; apply JW/JZ only when required; track renewal and filing dates.

Payer / plan / policy version / verification date

Authorization number / payer reference

Authorization valid from / through

Approved units / visits / frequency

Reviewer / date verified

Outstanding items / N/A rationale / reviewer and date

Prior authorization does not guarantee payment. Verify the member-specific policy before each submission.
Examples informed by payer guidance; not universal criteria or a complete safety checklist. Reviewed 2026-10-17.

Therapy policy example (click to open)
CMS drug billing guidance (click to open)