

Princeton / Somerset New Jersey  
49 Veronica Avenue  
Suite 202  
Somerset, NJ 08873

Long Branch  
422 Morris Avenue  
Suite 7  
Long branch, NJ 07740

Marlton  
127 Church Road  
Suite 600  
Marlton, NJ 08053



# Risankizumab-rzaa (Skyrizi)

## Provider Order Form

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**LABORATORY ORDERS**

CBC  at each dose  every \_\_\_\_\_

CMP  at each dose  every \_\_\_\_\_

Hepatic Function Panel  at each dose  every \_\_\_\_\_

Other: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV

methylprednisolone (Solu-Medrol)  40mg /  125mg IV

hydrocortisone (Solu-Cortef)  100mg IV

Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

**THERAPY ADMINISTRATION**

**Risankizumab-rzaa (Skyrizi) Induction IV dose**

- Dose: 600mg
- Frequency: week 0, week 4, and week 8
- Route: Intravenous
- Infuse over 60 minutes

Flush with 0.9% sodium chloride at the completion of infusion

Other \_\_\_\_\_

Patient required to stay for 30-min observation post procedure

Patient is NOT required to stay for observation time

Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

**Total Doses:**

Year \_\_\_\_\_

Other \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

### ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_