

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 _____