

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Risankizumab-rzaa (Skyrizi)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral	☐ Referral Renewal
☐ Medication/Order Change	☐ Benefits Verification Only
☐ 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:

☐ ICD-10*: _____

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, (Crohns dosing)
 - Frequency: week 0, week 4, and week 8
 - Route: Intravenous
 - Infuse over 60 minutes
- ☐ Dose: 1200mg for 3 doses, (UC dosing)
 - 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)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____