

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: _____

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 120 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 _____