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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 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 ______________