

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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

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 _____