

# Risankizumab-rzaa (Skyrizi IV)

Provider Order Form rev. 08/28/2024

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

|  |                               |                  |                     |
|--|-------------------------------|------------------|---------------------|
| Patient Name:  | DOB:                          | Patient Phone:   |                     |
| Patient Address:   | Patient Email:                |                  |                     |
| Allergies:   | <input type="checkbox"/> NKDA | Weight (lbs/kg): | Height (in/cm):     |
| Sex: <input type="checkbox"/> M / <input type="checkbox"/> F | Date of Last Infusion:        | Next Due Date:   | Preferred Location: |

## DIAGNOSIS (Please provide ICD-10 code in space provided)

|                                      |
|--------------------------------------|
| Crohn's Disease (IV dosing only):    |
| Ulcerative Colitis (IV dosing only): |

## THERAPY ADMINISTRATION & DOSING

Only IV induction dosing will be provided. Subcutaneous dosing **WILL NOT** be provided

### For Crohn's Disease:

Administer Risankizumab-rzaa (Skyrizi) 600mg IV over 1hour. Dilute in 100ml 0.9 NS or D5W

### For Ulcerative Colitis:

Administer Risankizumab-rzaa (Skyrizi) 1200mg IV over 2 hours. Dilute in 250ml 0.9 NS or D5W

## FREQUENCY (Choose one)

Induction: week 0, week 4, and week 8

## ADDITIONAL ORDERS

## LABORATORY ORDERS

Bilirubin, LFTs at week 8  
 Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

Tylenol  500mg /  650mg PO  
 Loratadine 10mg PO  
 Pepcid 20mg  PO /  IVP  
 Benadryl  25mg /  50mg  PO /  IVP  
 Solumedrol  40mg /  125mg IVP  
 Other: \_\_\_\_\_

## NURSING

Hold infusion and notify provider for:

- Signs or symptoms of illness/active infection or recent live vaccinations
- Elevated LFTs or bilirubin

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

|                          |                          |        |           |
|--------------------------|--------------------------|--------|-----------|
| Preferred Contact Name:  | Preferred Contact Email: |        |           |
| Ordering Provider:       | Provider NPI:            |        |           |
| Referring Practice Name: | Phone:                   | Fax:   |           |
| Practice Address:        | City:                    | State: | Zip Code: |

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with immunosuppressants, biologic agent and steroids, Colonoscopy  
**Required Labs:** TB, Hep B, CRP, ESR, LFTs and Bilirubin,

Provider Name (print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_