

Risankizumab-rzaa (Skyrizi IV)

Provider Order Form rev. 1/23/2025



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)

<input type="checkbox"/> K50. ____: Crohn's Disease	<input type="checkbox"/> K51. ____: Ulcerative Colitis
<input type="checkbox"/> Other:	Description:

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

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.