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: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

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

☐ K50. ____: Crohn's Disease ☐ K51. ____: Ulcerative Colitis

☐ 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.