

Risankizumab-rzaa (Skyrizi IV)

Provider Order Form rev. 7/30/2025



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.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.