Infusion Solutions Inc.
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SKYRIZI (risankizumab-rzaa) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____
ALLERGIES:_____

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: SKYRIZI (risankizumab-rzaa) ☐NO ☐YES
BRAND:_____ LAST DOSE DATE:_____
DIAGNOSIS:_____ ICD 10 CODE(S):_____

MEDICATION ORDERS

DOSE/FREQUENCY: Maintenance orders are valid for 1 year. For a shorter duration, indicate here: _____

☐ Crohn's Disease Induction: 600 mg IV at week 0, week 4 and week 8 only
☐ Ulcerative Colitis Induction: 1200 mg IV at week 0, week 4 and week 8 only

☐ Maintenance: ☐ 180 mg sub-Q at week 12 and every 8 weeks thereafter
☐ 360 mg sub-Q at week 12 and every 8 weeks thereafter

☐ Other: _____

STANDARD IV ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:
☐CMP ☐CBC w/diff
☐CRP (non-cardiac) ☐Other: _____

LAB FREQUENCY:
☐Every Dose
☐Other frequency: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- For Crohn's or Ulcerative Colitis, obtain liver enzymes and bilirubin levels before starting Skyrizi
- Quantiferon Gold lab result for TB screening

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline labs: CMP, CBC w/ diff
- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution) | *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) | *DATE*