Fax Form to: 330-294-2082

INDY INFUSION

# Risankizumab-rzaa (Skyrizi IV)

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

## PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

## NURSING

☑ TB status & date (list results here & attach clinicals)
_____

☑ Baseline Liver Enzymes, including bilirubin (results)

☑ Provide nursing care , including
reaction management and post procedure observation

## PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

## LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

## THERAPY ADMINISTRATION

☑ Risankizumab-rzaa (Skyrizi) induction IV dose

- Dose: 600mg
- Frequency: week 0, week 4, and week 8
- Route: Intravenous
- Infuse over 60 minutes
- ☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 30-min observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

Evaluate for TB prior to initiating treatment with SKYRIZI.

Hepatotoxicity in Treatment of Crohn's disease: Drug-induced liver injury during induction has been reported. Monitor liver enzymes and bilirubin levels at baseline and during induction, up to at least 12 weeks of treatment. Monitor thereafter according to routine patient management.

**Provider Name (Print)** **Provider Signature** **Date**

**Please include the following information when submitting a referral for Skyrizi:**

-Result of Tuberculosis (TB) skin/ lab testing
-Baseline Liver Enzymes and Bilirubin