

SKYRIZI™ (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:			ICD-10 Code:		
TB Status:	<input type="checkbox"/> PPD (negative) – date:	<input type="checkbox"/> Active TB			
	<input type="checkbox"/> Last chest x-ray – date:	<input type="checkbox"/> Unknown			
	<input type="checkbox"/> Past positive TB infection, course taken:				

Skyrizi™ (Risankizumab-rzaa) Prescription

Skyrizi™ (Risankizumab-rzaa) refill as directed x 1 year
Crohn's Disease
Induction Dose: IV: Infuse 600mg over at least 1 hour at Week 0, Week 4, and Week 8.

Ancillary Orders

Anaphylaxis Kit
 If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
 Yes No

Dosage:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SQ) access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

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