

SKYRIZI® (Risankizumab-rzaa) NURSING and ANCILLARY ORDER FORM

Patient Name:

DOB:

Gender:

Address:

Phone:

Clinical Information

Primary Diagnosis Description:

ICD-10 Code:

Allergies: NKDA OR (List):

TB Evaluation Status:

 Patient has been evaluated for tuberculosis (TB) infection prior to starting Skyrizi® treatment

- Date of evaluation/risk assessment: _____

- Provide clinical documentation of evaluation completed and/or TB test results with this order form (as applicable)

SKYRIZI® (Risankizumab-rzaa) Nursing and Ancillary Orders**Nursing Orders**

Skilled nurse to assess and administer Skyrizi and/or teach self-administration where appropriate via (IV/SUBQ) access device per prescriber medication order.

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) SUBQ 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.
 • 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Medication Orders

Diluents and Supplies necessary for the administration of the Skyrizi medication to be supplied by the administering pharmacy

Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 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: _____

Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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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