SKYRIZI® (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

TB Status:

☐ PPD (negative) – date:
☐ Last chest x-ray – date:
☐ QuantiFERON or T Spot Assay result and date:_____
☐ Active TB
☐ Unknown
☐ 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.

Maintenance Dose: ☐ SUBQ: Inject **180mg** starting at week 12, and every 8 weeks thereafter. (NDC 00074-1065-01 preferred)
☐ SUBQ: Inject **360mg** starting at week 12, and every 8 weeks thereafter. (NDC 00074-1070-01 preferred)

Ulcerative Colitis

Induction Dose: ☐ IV: Infuse **1200mg** over at least 2 hours at Week 0, Week 4, and Week 8.

Maintenance Dose: ☐ SUBQ: Inject **180mg** starting at week 12, and every 8 weeks thereafter. (NDC 00074-1065-01 preferred)
☐ SUBQ: Inject **360mg** starting at week 12, and every 8 weeks thereafter. (NDC 00074-1070-01 preferred)

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) 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

☐ 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: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SUBQ) access device as indicated above. Nurse will provide ongoing support as needed. 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:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

