

SKYRIZI® (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:			Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:
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"/> QuantiFERON or T Spot Assay result and date: _____ <input type="checkbox"/> Past positive TB infection, course taken: _____				
Skyrizi® (Risankizumab-rzaa) Prescription					
Skyrizi® (Risankizumab-rzaa) refill as directed x 1 year <u>Crohn's Disease</u> Induction Dose: <input type="checkbox"/> IV: Infuse 600mg over at least 1 hour at Week 0, Week 4, and Week 8. Maintenance Dose: <input type="checkbox"/> SUBQ: Inject 180mg starting at week 12, and every 8 weeks thereafter. (NDC 00074-1065-01 preferred) <input type="checkbox"/> SUBQ: Inject 360mg starting at week 12, and every 8 weeks thereafter. (NDC 00074-1070-01 preferred) <u>Ulcerative Colitis</u> Induction Dose: <input type="checkbox"/> IV: Infuse 1200mg over at least 2 hours at Week 0, Week 4, and Week 8. Maintenance Dose: <input type="checkbox"/> SUBQ: Inject 180mg starting at week 12, and every 8 weeks thereafter. (NDC 00074-1065-01 preferred) <input type="checkbox"/> 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 1 st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 st dose? <input type="checkbox"/> Yes <input type="checkbox"/> No Dosage: <ul style="list-style-type: none"> 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 <input type="checkbox"/> Other: _____					
IV Flush Orders <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> <u>Implanted Port:</u> 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
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					
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