SKYRIZI® (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		
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.
☐ SubQ: Inject **360mg** starting at week 12, and every 8 weeks thereafter.

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.
☐ SubQ: Inject **360mg** starting at week 12, and every 8 weeks thereafter.

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.

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:

