

# 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: \_\_\_\_\_  Active TB  
 Last chest x-ray – date: \_\_\_\_\_  Unknown  
 QuantIFERON or T Spot Assay result and date: \_\_\_\_\_  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 1<sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> 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:

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