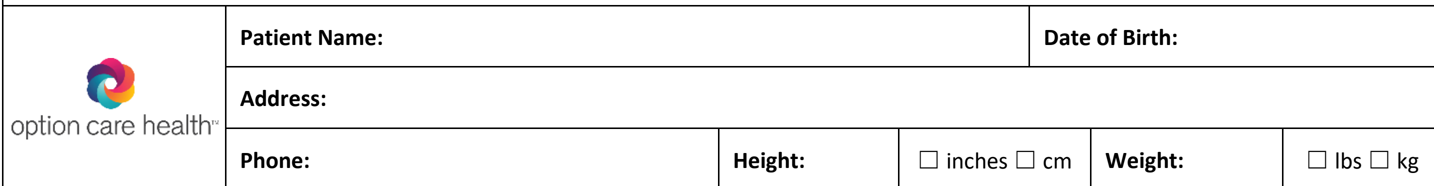
SKYRIZI™ (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



option care health™	**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:
- ☐ Past positive TB infection, course taken:
- ☐ Active TB
- ☐ Unknown

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 360 mg SQ 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 – please complete Anaphylaxis Physician Order (FR-PC-036) provided ☐ No

Medication Orders

☐ Other: ______________________________

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 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/SQ) 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:**	

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