Risankizumab-rzaa (Skyrizi IV)

Provider Order Form *rev. 06/11/2024*

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PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (list results here & attach clinicals)

_____

☑ Baseline Liver Enzymes, including bilirubin (results)

_____

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post- procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ Risankizumab-rzaa (Skyrizi) induction IV dose

- Dose: 600mg
- Frequency: week 0, week 4, and week 8
- Route: Intravenous
- Infuse over 60 minutes

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient required to stay for 30-min observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Evaluate for TB prior to initiating treatment with SKYRIZI.

Hepatotoxicity in Treatment of Crohn's disease: Drug-induced liver injury during induction has been reported. Monitor liver enzymes and bilirubin levels at baseline and during induction, up to at least 12 weeks of treatment. Monitor thereafter according to routine patient management.

Provider Name (Print) **Provider Signature** **Date**

Email info@ivcareinfusion.com or fax this Form, Insurance card (both sides), Demographics, Recent H&P, Labs & supporting Clinicals to:

FAX NUMBER FOR SKYRIZI REFERRALS: (615) 471-8674