

Skyrizi (risankizumab-rzaa) Infusion/Injection Orders

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code) _____

New Start Therapy Continuation of Therapy _____ Date of last dose (if applicable): _____

NKDA Allergies: _____

Ordering Provider: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

PRE-MEDICATION

- Acetaminophen 1000mg PO
- Diphenhydramine 25mg
- PO Ceterizine 10mg PO
- Solu-Medrol 125mg IVP
- Solu-Cortef 100mg IVP
- Diphenhydramine 25mg IVP

REQUIRED TESTING/LABS

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
- TB status and date (please attach results): _____
- CMP (LFTs and Bilirubin should be monitored at baseline, during induction, and periodically)

SKYRIZI ORDERS

Initial Skyrizi Induction Infusion:

Dilute in 250ml D5W and administer intravenously over 1 hour

- 600mg IV Infusion @ week 0, 4, and 8
- Other: _____

**Maintenance dose: 360mg subcutaneously at week 12, then every 8 weeks thereafter to be administered in home setting via OBI*

Infuse One Standing Orders:

- Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date