RED RIVER HEALTH
Ambulatory Infusion Clinic

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SKYRIZI (Risankizumab-rzaa) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

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

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Plaque Psoriasis

☐ _____ Psoriatic Arthritis

☐ _____ Crohn's Disease

☐ _____ _____ *other*

Pre-Medication:

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Other: _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

☑ TB Status & Date *(please attach results)*

☑ CMP (LFTs & bili should be monitored at baseline, during induction, and periodically)

SKYRIZI ORDERS:

Initial Induction Dosing & Frequency:

☑ dilute in 250 ml NS 0.9%, administer IV over 1 hour
☐ 600mg @ week 0, 4, and 8

☐ Other: _____

**follow-up maintenance injections to be coordinated by a specialty pharmacy and are <u>not</u> part of this order.*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: