COASTAL INFUSION SERVICES

1922 Highway 22 W, Suite A
Madisonville, LA 70447
Local: 985-792-9001

Toll-Free: 833-285-5500
Fax: 985-792-9004
Toll-Free: 833-235-1686

Skyrizi (Risankizumab-rzaa)|Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. **For new patients, please submit with form:** ● Copy of insurance card ● Demographics
   ● History & physical ● Labs (including baseline liver enzymes and bilirubin) ● Tuberculosis (TB) test results

2. **Patient Information**
   ○Male ○Female Height: _____ ○in/○cm Weight: _____ ○lbs/○kg ☐NKDA Allergies_____
   Line type (if applicable): ☐PIV ☐PICC ☐Port ☐Other information: _____

3. **Diagnosis and Clinical Information** ICD-10 (required): _____
   ☐Crohn's disease ☐Ulcerative colitis ☐Plaque psoriasis ☐Psoriatic arthritis ☐Other: _____

4. **Prescription Information:**

Indication	Skyrizi Dosing
Crohn's Disease	☐ **Induction:** Infuse 600 mg IV over at least 1 hour at weeks 0, 4, and 8 ☐ **Maintenance:** ○180 mg OR ○360 mg subcutaneously at week 12, then every 8 weeks
Ulcerative Colitis	☐ **Induction:** Infuse 1200 mg IV over at least 2 hours at weeks 0, 4, and 8 ☐ **Maintenance:** ○180 mg OR ○360 mg subcutaneously at week 12, then every 8 weeks
Psoriatic Arthritis, Plaque Psoriasis	☐ **Induction:** Inject 150 mg subcutaneously at weeks 0 and 4 ☐ **Maintenance:** Inject 150 mg subcutaneously every 12 weeks
Other	☐ _____
Quantity / Refills	Dispense 1 month supply / QS on all medications. Dispense medical supplies for administration Refill x 12 months OR ☐Other: _____

5. **Additional Orders**
   - For IV infusions: RN to start peripheral IV or use existing CVC. Administer catheter flushing per Coastal Infusion Services Policy & Procedure. Prepare per manufacturer guidelines using compatible IV solution for dilution prior to infusion.
   - For SQ injections: Provide skilled nursing to teach injection technique if needed
   - **Premedication:** Give 30 min prior to IV infusion (*Note: if nothing is checked, no premedications will be given*)
     ☐ Diphenhydramine 25-50mg PO. Patient may decline.
     ☐ Acetaminophen 325-650mg PO. Patient may decline.
     ☐ Methylprednisolone 40mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitute if needed)
   - **Other orders:** _____
   - RN to monitor patient post-infusion per Coastal Infusion Services Policy & Procedure and educate on possible side effects, allergic reactions, and when to contact physician

6. **Adverse Reaction Orders:** For first doses, standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV.

7. **Prescriber Information**
   Prescriber Name: _____Contact: _____ Phone: _____ Fax: _____
   Address: _____ City: _____ State: _____ Zip: _____
   License No.: _____ DEA No.: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.