

Skyrizi (Risankizumab-rzaa) | Order Form

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

1. **For new patients, please submit with form:**
- History & physical
 - Labs (including baseline liver enzymes and bilirubin)
 - Copy of insurance card
 - Demographics
 - 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	<input type="checkbox"/> Induction: Infuse 600 mg IV over at least 1 hour at weeks 0, 4, and 8 <input type="checkbox"/> Maintenance: <input type="radio"/> 180 mg OR <input type="radio"/> 360 mg subcutaneously at week 12, then every 8 weeks
Ulcerative Colitis	<input type="checkbox"/> Induction: Infuse 1200 mg IV over at least 2 hours at weeks 0, 4, and 8 <input type="checkbox"/> Maintenance: <input type="radio"/> 180 mg OR <input type="radio"/> 360 mg subcutaneously at week 12, then every 8 weeks
Psoriatic Arthritis, Plaque Psoriasis	<input type="checkbox"/> Induction: Inject 150 mg subcutaneously at weeks 0 and 4 <input type="checkbox"/> Maintenance: Inject 150 mg subcutaneously every 12 weeks
Other	<input type="checkbox"/> _____
Quantity / Refills	Dispense 1 month supply / QS on all medications. Dispense medical supplies for administration Refill x 12 months OR <input type="checkbox"/> 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.