NORMAN REGIONAL Health System

# Outpatient Infusion Center

Fax: 405-307-2244
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ORD

# Risankizumab (Skyrizi)

## Patient and Physician Information

| Patient Name: | Date of Birth: | Patient Phone Number: |
|---|---|---|
| | | |
| **Physician Name:** | **Office Phone Number:** | **Fax Number:** |
| | | |
| **Insurance:** | **Group Number:** | **Policy Number:** |
| | | |
| **Hospitalization Status:** | **Patient Weight (kg):** | **Height (inches):** |
| ☑ Outpatient to Outpatient Infusion Center | | |
| **Allergies:** | | |
| | | |

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

## Diagnosis Code/Description for treatment: _____

☐ Adult Crohn Disease (K50.00)
☐ Adult Ulcerative Colitis, unspecified (K51.90)

## Laboratory

☐ CBC WITH DIFFERENTIAL ☐ COMPREHENSIVE METABOLIC PANEL
Other: _____

## Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

## Infusion – Risankizumab (Skyrizi) [J2327 : 1 MG = 1 unit]

***Ulcerative Colitis***
☐ Risankizumab (Skyrizi) 1200 MG in 250 mL of 5% Dextrose Solution INTRAVENOUS ONCE over 120 minutes.

***Crohn's Disease***
☐ Risankizumab (Skyrizi) 600 MG in 250 mL of 5% Dextrose Solution INTRAVENOUS ONCE over 60 minutes.

Date of Service: First Dose (_____) next initial dose 4 weeks after first initial dose, then 3rd dose is 8 weeks after first initial dose. If patient tolerates doses, may begin self-administering maintenance dosing at week 12.

## Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

## Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

## Date and Physician Signature

**DATE:**_____ **TIME:**_____

_____
**PHYSICIAN'S SIGNATURE**

11222510



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