

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):
<input checked="" type="checkbox"/> 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: _____
 11222512

TIME: _____

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PHYSICIAN'S SIGNATURE

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES