Skyrizi (Risankizumab) Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs (including TB Test and baseline LFTs and Bilirubin), and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:

☐ Crohn's Disease (ICD-10 _____)
☐ Ulcerative Colitis (ICD-10 _____)
☐ Other (ICD-10 _____)

Induction Dose: ☐ Skyrizi 600 mg in 100 mL NS IV to be infused over 1 hour at week 0, 4, and 8

☐ Skyrizi 1200 mg in 250 mL NS IV to be infused over 2 hours at week 0, 4, and 8

Maintenance Dose: ☐ Skyrizi 360 mg subcutaneously starting at week 12, then every 8 weeks

Refill: ☐ PRN x 1 year OR _____ times

Pre-Medication Orders (optional):

☐ Acetaminophen 650 mg PO OR ☐ Acetaminophen 1000 mg PO

☐ Diphenhydramine 25 mg PO OR ☐ Cetirizine 10 mg PO

☐ Other: _____

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

LFTs and Bilirubin should be monitored at baseline, during induction, and at regular intervals while on therapy

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

☐ May use Burnham's Vital Care flush and catheter maintenance protocol

Nursing Orders: ☐ Pharmacy to provide nursing services, including vascular access, administration, and line care

☐ May use Burnham's Vital Care anaphylaxis protocol

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		