

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:		

ALABAMA

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