

Risankizumab-rzaa (Skyrizi)



Provider Order Form rev. 6/23/22

PATIENT INFORMATION

| | | |
|--|----------------------|----------------|
| Date: | Patient Name: | DOB: |
| ICD-10 code (required): | ICD-10 description: | |
| <input type="checkbox"/> NKDA Allergies: | Weight lbs/kg: | |
| Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy | Last Treatment Date: | Next Due Date: |

PROVIDER INFORMATION

| | | | |
|----------------------------|-----------------------------|--------|-----------|
| Referral Coordinator Name: | Referral Coordinator Email: | | |
| Ordering Provider: | Provider NPI: | | |
| Referring Practice Name: | Phone: | Fax: | |
| Practice Address: | City: | State: | Zip Code: |

NURSING

- TB status and date (results) _____
 - Baseline Liver Enzymes including bilirubin _____
 - Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
- NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

THERAPY ADMINISTRATION

- Risankizumab-rzaa** (Skyrizi) Induction IV dose
 - Dose: 600mg
 - Frequency: week 0, week 4, and week 8
 - Route: Intravenous
 - Infuse over 60 minutes
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient required to stay for 30-min observation post procedure
- Patient is NOT required to stay for observation time
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Hepatic Function Panel at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

Evaluate for TB prior to initiating treatment with SKYRIZI.

Hepatotoxicity in Treatment of Crohn's disease: Drug-induced liver injury during induction has been reported. Monitor liver enzymes and bilirubin levels at baseline and during induction, up to at least 12 weeks of treatment. Monitor thereafter according to routine patient management.

Provider Name (Print) _____ Provider Signature _____ Date _____

| | | | | |
|---|---|---|---|---|
| FAX NUMBERS | <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> SARASOTA: 941-870-6550 | <input type="checkbox"/> EAST TN: 615-425-7427 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARTFORD: 860-955-1532 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 | |
| | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> TAMPA: 844-946-0849 | | |