

**SKYRIZI® (RISANKIZUMAB-RZAA) PRESCRIBER ORDER FORM**

**FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to (757) 466-1128**

**NEW PATIENT** OR

**CHANGE ORDER:**      **Drug Change**      **Dose Change**      **Interval Change**

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Allergies: \_\_\_\_\_

Height:             inches  cm            Weight:             lbs  kg

**CLINICAL INFORMATION**

**Primary Diagnosis Description:** \_\_\_\_\_ **ICD-10 Code:** \_\_\_\_\_

**Is this the first dose?**     Yes  
    No – date of next dose due: \_\_\_\_\_

**Treatments Tried and Failed:**

**TB Status:**             PPD (negative) – date: \_\_\_\_\_             Active TB             Unknown  
                                  Last chest X-ray – date: \_\_\_\_\_             Other: \_\_\_\_\_  
                                  Past positive TB infection, course taken: \_\_\_\_\_

**SKYRIZI® (RISANKIZUMAB-RZAA) PRESCRIPTION**

**SKYRIZI® (RISANKIZUMAB-RZAA) refill as directed x 1 year**

**Crohn's Disease**

*Induction Dose:*             IV: Infuse 600mg over at least 1 hour at week 0, week 4, and week 8.

*Maintenance Dose:*     SubQ: Inject 180mg starting at week 12 and every 8 weeks thereafter.  
    SubQ: Inject 360mg starting at week 12 and every 8 weeks thereafter.

**Ulcerative Colitis:**

*Induction Dose:*             IV: Infuse 1200mg over at least 2 hours at week 0, week 4, and week 8.

*Maintenance Dose:*     SubQ: Inject 180mg starting at week 12 and every 8 weeks thereafter.  
    SubQ: Inject 360mg starting at week 12 and every 8 weeks thereafter.

**ANCILLARY ORDERS**

**Pre - Medication Orders:**

- Acetaminophen 650mg PO 30 minutes before infusion.
- Diphenhydramine 25mg PO/IV 30 minutes before infusion.
- Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
- Other: \_\_\_\_\_

**PRN Hypersensitivity Meds:**

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PRESCRIBER INFORMATION**

**Prescriber Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **NPI:** \_\_\_\_\_

**City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Office Contact:** \_\_\_\_\_

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