MRN:_____
DOB: _____

Standard Plan of Treatment for Skyrizi® (risankizumab-rzaa) for Gastroenterology

NOTE: *Patient **may be ineligible** to receive Risankizumab-rzaa if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.*

1. **Patient Name**: _____Height (in.):_____ Weight (lbs):_____
2. **Allergies**: _____
3. **Diagnosis:**

☐ K50.0_____ Crohn's Disease (small intestine) ☐ K50.8 _____ Crohn's Disease (small & large intestine)

☐ K50.1_____ Crohn's Disease (large intestine) ☐ K50.9 _____ Crohn's Disease, unspecified

☐ Other ICD-10 Code: _____ Diagnosis Description: _____

4. **Pre-medication:** ***Administered 30 minutes prior to infusion as selected***

Acetaminophen:	Diphenhydramine: □ 25 mg PO □ 50 mg PO □ 25 mg IV □ 50 mg IV *or*
☐ 1000mg PO	Fexofenadine: □ 60mg □ 180 mg *or* □ Cetirizine 10 mg *or*
☐ 650mg PO	□Loratadine10mg
☐ 500mg PO	Methylprednisolone: □ 40 mg IV □ 125 mg IV or other_____mg IV
☐ 325mg PO	Famotidine: □ 20 mg PO □ 40 mg PO □ 20 mg IV □ 40mg IV

Premedicate with other:_____

5. **Order:**

☐ **Induction: Skyrizi® (risankizumab-rzaa) 600mg/10ml in 5% Dextrose ☐ 100ml ☐ 250ml or ☐ 500ml administered by intravenous infusion over at least one hour at week 0, week 4, and week 8**

Last known therapy: _____ and last date received: _____. MD to specify wash-out period prior to starting Skyrizi® as specified of _____ weeks since last dose of prior therapy.

Lab orders with infusion: _____
_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. **Physician's Signature**:_____/_____ **Date**: _____
(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

7. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

MRN:_____
DOB: _____

Guidelines for Prescribing Skyrizi® (risankizumab-rzaa) for Gastroenterology

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

☐ Recommended to complete all age-appropriate vaccinations as recommended by immunization guidelines

☐ Send additional prescription to specialty pharmacy for Skyrizi® on-body subcutaneous injection for maintenance dosing regimen.

☐ Other as requested: _____
_____

Required Pre-Screening:

☐ Baseline liver enzymes

☐ Baseline bilirubin levels

WARNINGS & PRECAUTIONS

•Hypersensitivity Reactions: Serious hypersensitivity reactions, including anaphylaxis, may occur (5.1)• Infections: SKYRIZI may increase the risk of infection. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If such an infection develops, do not administer SKYRIZI until the infection resolves. (5.2) • Tuberculosis (TB): Evaluate for TB prior to initiating treatment with SKYRIZI. (5.3) • 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. (5.4) • Administration of Vaccines: Avoid use of live vaccines. (5.5)

AccuRx Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.