Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

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

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	K50.0_____ - Crohn's Disease (small intestine)	☐	K50.1_____ - Crohn's Disease (large intestine)
☐	K50.8_____ - Crohn's Disease (small & large intestine)	☐	K50.9_____ - Crohn's Disease
☐	_____- Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	**REQUIRED:** TB screening for new start patients
6	Baseline LFTs and bilirubin level

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	☐ 25mg	☐ 50mg					
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:				
	Famotidine	☐ 20mg	☐ 40 mg					
	Other:	☐						
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg			
	Famotidine	☐ 20mg	☐ 40mg					
	Diphenhydramine	☐ 25mg	☐ 50mg					
	Fexofenadine	☐ 60mg	☐ 180mg					
	Cetirizine	☐ 10mg						
	Loratadine	☐ 10mg						
	Other:	☐						

MEDICATION/DOSE:

☑ Skyrizi® (risankizumab-rzaa) 600mg/10ml in 100ml-500ml of NS given IV over at least 1 hour

FREQUENCY:

☐ Week 0, week 4, and week 8

☐ Other: _____

SPECIAL/OTHER LAB ORDERS:

☐ _____

_____

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	