

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Skyrizi® (risankizumab-rzaa) Standard Plan of Treatment for Ulcerative Colitis

### 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 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

K51.0 - Ulcerative (Chronic) Pancolitis	K51.4 - Inflammatory Polyps of Colon
K51.2 - Ulcerative (Chronic) Proctitis	K51.5 - Left Sided Colitis
K51.3 - Ulcerative (Chronic) Rectosigmoiditis	K51.8 - Other Ulcerative Colitis or Unspecified
- Other:	

### REQUESTED DOCUMENTATION:

### PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	<b>REQUIRED:</b> TB screening for new start	THERAPY:	
6	Baseline LFTs and bilirubin level		
			<b>Continue current order until insurance approved</b>

### 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

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

### MEDICATION/DOSE:

Skyrizi® (risankizumab-rzaa) 1200mg in 250ml or 500ml of NS given IV over at least 2 hours

### SPECIAL/OTHER LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

### FREQUENCY:

Week 0, week 4, and week 8

Other: \_\_\_\_\_

### 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



# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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**

Palmetto 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)