

AMBULATORY INFUSION AND IN HOME ORDERS/SPECIALTY ORDERS

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 Crohn's Disease

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name: _____
 Patient's Phone: _____ 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:

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	IF ORDER CHANGE:
5	REQUIRED: TB screening for new start	THERAPY:	
6	Baseline LFTs and bilirubin level		
			Continue current order until insurance approved

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

INDUCTION DOSE:

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

IV-FREQUENCY:

Week 0, week 4, and week 8
 Other: _____

SPECIAL/OTHER LAB ORDERS:

IN HOME/SPECIALTY PHARMACY ORDERS:

MAINTENANCE DOSE:

Skyrizi® (risankizumab-rzaa) 180mg given subcutaneously
 Skyrizi® (risankizumab-rzaa) 360mg given subcutaneously

Some commercial insurance plans require maintenance doses to be provided by the plan's specialty pharmacy. Providers will be notified if Palmetto Infusion cannot dispense the maintenance doses due to plan restrictions or patient preference.

FREQUENCY:

At week 12 and then every 8 weeks thereafter
 Other: _____

Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

- Start PIV/Access CVC.
- Flush device per facility standard flushing procedure.
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.
- In Home Supply orders: All supplies for drug administration and adverse reaction kit for in home use will be provided.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion AIC standing adverse reaction orders. Home Standing orders including Home Anaphylaxis Kit dispense as written and administer for mild and severe reaction are provided

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



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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com