Palmetto INFUSION®

AMBULATORY INFUSION AND IN HOME ORDERS/SPECIALTY ORDERS		
Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

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

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

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)

☐	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:

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

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					
	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:	☐								

INDUCTION DOSE:

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

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

FREQUENCY:

☐ At week 12 and then every 8 weeks thereafter

☐ Other:_____

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.

☑ 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	