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

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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start		☐ **Continue current order until insurance approved**
6	Baseline LFTs and bilirubin level		

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) 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	

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 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