BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

SKYRIZI (RISANKIZUMAB-RZAA) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Crohn's Disease ICD-10 Code: _____ ☐ Psoriatic Arthritis ICD-10 Code: _____

☐ Ulcerative Colitis ICD-10 Code: _____ ☐ Diagnosis: _____ ICD-10 Code: _____

☐ Plaque Psoriasis ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider ☐ TB Test Results

☐ Patient demographics AND insurance information ☐ Labs and Tests supporting primary diagnosis

☐ H&P and Clinical/Progress notes supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment: 1) _____ 2) _____

MEDICATION ORDERS

Medication	Indication	Dose	Route	Frequency
■ Skyrizi (Risankizumab-rzaa)	Plaque Psoriasis or Psoriatic Arthritis	☐ 150 mg	SubQ	Week 0, 4, and every 12 weeks thereafter
	Crohn's Disease	Induction: ☐ 600mg infused over 60 minutes	IV	Week 0, 4, 8
		Maintenance: ☐ 180mg ☐ 360mg	SubQ	Week 12, then every 8 weeks thereafter
	Ulcerative Colitis	Induction: ☐ 1200mg infused over 120 minutes	IV	Week 0, 4, 8
		Maintenance: ☐ 180mg ☐ 360mg	SubQ	Week 12, then every 8 weeks thereafter

Hepatotoxicity in treatment of Inflammatory Bowel Disease. Drug induced liver injury during induction has been reported. Monitor LFT's and bilirubin at baseline and during induction, up to at least 12 weeks of treatment. Monitor thereafter according to routine patient management.

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

**(if not indicated, order will expire 1 year from date signed)*

■ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

■ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

■ RN to flush and lock VAD/CVAD per company protocol

Other: _____

EMERGENCY MEDICATIONS

■ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

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