Local Infusion

MYLOCALINFUSION.COM

SKYRIZI (RISANKIZUMAB-RZAA) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Crohn's Disease, ICD 10: K50._____ ❑ Ulcerative Colitis, ICD 10: K51._____

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Skyrizi	Crohn's: 600 mg Ulcerative Colitis: 1200 mg	IV	Weeks 0, 4, 8
	Then maintenance dosing ❑ 180 mg or ❑ 360 mg	Subcutaneous inj.	Week 12, then every 8 weeks

x3 IV infusions need to be completed prior to SubQ injections.

❑ Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS