



Skyrizi

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			

REQUIRED DOCUMENTATION

Labs (Liver Enzyme, Bilirubin, TB)		
Insurance Card (front and back)	Current Medications	History/Progress Notes

ICD-10 CODE

K50.90 Crohn's disease	K51.90 Ulcerative colitis, unspecified, without complications	Other: _____
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PRE-MEDICATION ORDER

Acetaminophen (Tylenol)	500mg	650mg	1000mg PO	Diphenhydramine (Benadryl)	25mg	50mg	PO	IV
Cetirizine (Zyrtec)	10mg PO			Methylprednisolone (Solu-Medrol)	40mg IV	125mg IV		
Loratadine (Claritin)	10mg PO			Hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____	Dose: _____	Route: _____	Frequency: _____					

MEDICATION ORDER

Skyrizi (Risankizumab-rzaa)	Dose:	600mg IV	1200mg IV	Frequency:	Week 0, week 4 and week 8
<i>Note: Administration will use the 600mg/10ml SDV</i>					

PROVIDER INFORMATION

Provider Name:	Provider Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

SPECIAL INSTRUCTIONS

_____ Provider Name	_____ Provider Signature	_____ Date	_____ Check here if this is a stat order
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Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.