InfuseAble Care

Patient Name
DOB
Cell Phone
Address

SKYRIZI (risankizumab)

Status	☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change
Diagnosis	☐ ICD 10: K50.__ Crohn's Disease (CD) ☐ ICD 10 Code: _____ Other: _____
Pertinent Medical Hx	TB Status & Date: _____ Please send recent bilirubin & liver enzymes results prior to treatment.
Labs	Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: _____
Premeds	☐ No premeds necessary ☐ Other: _____
IV Fluids	☐ NS TKO ☐ Other: _____
Medication Order	Induction: ☐ Skyrizi 600mg IV at Week 0, Week 4, and Week 8. Maintenance: ☐ Skyrizi 360mg SubQ at Week 12 and every 8 weeks thereafter. Infusion Clinic will coordinate with Specialty Pharmacy for dispensing maintenance doses for self-administration by patient. Refills: ☐ x 1 year ☐ x _____doses ☐ No refills; give this dose only.
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 30 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.
Additional Orders	
Physician Information	Physician Name _____ NPI _____ Office Contact _____ Phone _____ **Provider Signature:** _____ Date _____

REQUIRED DOCUMENTATION

○ Patient Demographics & **Insurance** Information:	–	Copy of patient's insurance card – front and back
○ **Clinical / Progress Notes**, supporting primary diagnosis:	–	2 most recent office notes
	–	Medication history
○ Most Recent **Labs**:	–	CMP and CBC
	–	TB screening (PPD, QFT Gold or TSpot)
	–	Baseline Liver Enzymes & Bilirubin

FAX to (480) 400-6121
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