Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Risankizumab-rzaa)

Skyrizi infusion orders

Patient Name ______________________________ DOB ____________

Phone Number ___________________________ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ ___________________ Crohn's Disease ☐ ______________________ Other

PRE-MEDICATIONS

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ ____________________ (other)
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ __________________ (other)

Skyrizi (Risankizumab-rzaa) ORDERS

DOSAGE & FREQUENCY

☐ 600mg IV over 60 minutes at week 0, week 4, & week 8, followed by SQ injections self-administered.
(follow-up maintenance injections to be coordinated by a specialty pharmacy & are not part of this order)

Patient Weight
________ **lbs**
________ **kg**

NOTES:

ORDERING PROVIDER

Signature ______________________________ Phone________________Fax________________

Provider ____________________________________ Date _______________