Provider Order Form

SKYRIZI (RISANKIZUMAB-RZAA)

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ____________

Mobile Phone: ______________________ Weight: _______ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ___________ Next Treatment Date: ___________

DIAGNOSIS ICD-10 code (must be specified)

☐ Crohn's Disease K50. ______________________

☐ Ulcerative Colitis ICD 10: K51. ______________________

☐ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: ______________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Skyrizi (Risankizumab-rzaa), IV	☐ 600 mg (Crohn's disease - infuse over 60 minutes)	☐ week 0, week 4, and week 8
	☐ 1200 mg (Ulcerative disease - infuse over 120 minutes)	

Refills ☐ Zero ☐ 12 months ☐ ______________. Order valid for 1 year unless otherwise stated. ______________.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ___________

☐ CMP ☐ at each dose ☐ every ___________

☐ CRP ☐ at each dose ☐ every ___________

☐ Other ______________

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Liver enzymes and Bilirubin

______________________________ Provider Signature

______________________________ Date