

Skyrizi

(Risankizumab-rzaa)

Infusion Order



249 Danbury Rd. Wilton, CT 06897
 400 Columbus Ave, Valhalla, NY 10595
 127 Washington Ave, North Haven, CT 06473

Ph: 203-883-0038 Fax: 203-724-4838

Patient Name: _____

DOB: ____/____/____ M F

Allergies: _____

Phone: _____

Diagnosis: _____

ICD- 10: _____

Please fax a copy of the following patient information:

- Demographics
- Recent Progress Note
- Lab Results: LFT's, Bilirubin Level, Negative TB Test

TB-PPD / QuantiFERON Test Date: ____/____/____

Result: _____

Liver Function Test Date: ____/____/____

Bilirubin Level Test Date: ____/____/____

***Lab results are required prior to initiation and are to be repeated at or after the Week 8 Loading Dose.**

PRE- MEDICATION

- Acetaminophen 1000mg PO
- Solu- Medrol 125mg IVP
- Diphenhydramine 25mg PO
- Solu- Cortef 100mg IVP
- Cetirizine 10mg PO
- Diphenhydramine 25mg IVP
- No Pre-med
- Other: _____

SKYRIZI ORDER

DOSAGE

600mg IV

Patient Weight: _____ lbs / kg

Height: _____ ft _____ in

FREQUENCY

Loading Doses Weeks 0, 4, & 8

LABS

Check this box as an order for CIVIC to draw LFT's and Bilirubin levels at Week 8 Infusion Visit

NOTES:

Provider's Name: _____ Signature: _____

NPI: _____ Date: _____ Ph: _____ Fax: _____