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:

☐ **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
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ No Pre-med
☐ Solu- Medrol 125mg IVP
☐ Solu- Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
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:

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Provider's Name: ________________________________ Signature: _____________________________________

NPI: _________________ Date: ____________________ Ph: __________________ Fax: __________________