# Skyrizi

(risankizumab-rzaa)

Advanced Infusion Care Centers

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

## PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complication
☐ K50.019 Crohn's disease of small intestine w/unspecified complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.119 Crohn's disease of large intestine with unspecified comps
☐ K50.80 Crohn's disease of both small & large int without comps
☐ K50.819 Crohn's disease of both small & large int w/unsp comp
☐ K50.90 Crohn's disease, without complication
☐ K50.919 Crohn's disease, unspecified, with unspecified comps
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
☐ K51.019 Ulcerative (chronic) pancolitis with unsp complications
☐ K51.80 Other ulcerative colitis without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ Other: _____

## PRESCRIPTION

**Skyrizi Induction**

☐ (Crohn's Disease) 600mg IV at week 0, 4, and 8
☐ (Ulcerative Colitis) 1200mg IV at week 0, 4, and 8

**Skyrizi Maintenance** (to be filled by AIC Specialty Pharmacy or insurance plan mandated specialty pharmacy)

☐ 180mg subQ at week 12, then every 8 weeks thereafter x 1 year
☐ 360mg subQ at week 12, then every 8 weeks thereafter x 1 year
☐ Provider's Office will coordinate maintenance dose from Specialty Pharmacy
☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Negative TB results
- Tried/Failed Therapies
- Most recent labs
- Baseline LFTs (if available)

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.
☐ Provider Prescribed: _____

### LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*