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FAX 833.329.4738

Skyrizi (Risankizumab-rzaa)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Next Due Date (if applicable):

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Liver Enzyme, Bilirubin, TB)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ K50.90 Crohn's disease ◯ Other: _____

Pre-Medication Order

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

cetirizine (Zyrtec) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

Medication Order

Skyrizi (Risankizumab-rzaa) **Dose:** ◯ 600mg IV **Frequency:** ◯ Week 0, week 4 and week 8

Note: Administration will use the 600mg/10ml SDV

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯