Phone and Fax: 608-690-7210
www.MySmartInfusion.com

Skyrizi (Risankizumab-rzaa)
Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Psoriatic Arthritis ICD 10 Code: L40.50 ☐ Plaque Psoriasis ICD 10 Code: L40.0

☐ Crohn's Disease ICD 10 Code: K50.90

Required Labs

TB/QuantiFERON (within 12 months & attach results)

Baseline Liver Function Status & Date: _____

Most recent CBC & CMP (attach results)

Pre-Medication Orders

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

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

Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV

Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV

Other: _____ Route: _____

Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Skyrizi Medication Order

Patient Weight: _____ KG

Infusion Dosage

☐ 600mg IV ☐ Other _____

Frequency: Induction week 0, 4, and 8

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Location

☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____