Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare MedFuse

Skyrizi (Risankizumab-rzaa) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ CMP (LFTs and Bilirubin) lab results
□ TB status and date
□ Other:

Patient height and weight:

Patient Height (cm): Patient Weight (kg):

Skyrizi Medication Order

□ Initial induction IV dose
- 600mg IV on weeks 0, 4, and 8

□ Subsequent maintenance dosing:
- 360mg subcutaneously at week 12
- 360mg subcutaneously every 8 weeks thereafter

□ Maintenance only dosing every 8 weeks:
- 360mg subcutaneously every 8 weeks

Last Dose: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____