

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: \_\_\_\_\_ Crohn's Disease (CD) ICD-10 Code: K50. \_\_\_\_\_  
 \_\_\_\_\_ Ulcerative colitis (UC) ICD-10 Code: K51. \_\_\_\_\_  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical notes, labs, test supporting primary diagnosis
- Recent Lab Results including any recent antibody testing results
  - o Tuberculosis (TB) screening results
  - o Liver Enzymes and bilirubin levels
- Medication List

<b>Patient</b>
<b>Weight:</b> _____ lbs.
<b>Height:</b> _____ in.

**SKYRIZI® (risankizumab-rzaa)**

**4. Drug Order:**

**Induction Dosing (IV)** (J2327) \*Doses authorized: 3 (three)

- Crohn's Disease (IV):** Infuse 600 mg over at least 1 hour at Week 0, Week 4, and Week 8.
- Ulcerative Colitis (IV):** Infuse 1200 mg over at least 1 hour at Week 0, Week 4, and Week 8.

**Maintenance Dosing (SubQ)** (J3590) \*refill as directed x 1 year

- SUBQ:** Inject 180 mg starting at week 12, and every 8 weeks thereafter.
- SUBQ:** Inject 360 mg starting at week 12, and every 8 weeks thereafter.

**Other:** \_\_\_\_\_

**Pre-Medication Orders:** \_\_\_\_\_

No Pre-medications are recommended based on manufacturer guidelines.

**Lab Orders:** Infusion center to obtain liver enzymes and bilirubin at week: \_\_\_ during Induction (IV) dosing. Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol. Anaphylaxis Kit:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

Dispense as written

Substitution permitted

Printed Physician's Name with Credentials: \_\_\_\_\_ Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>CENTRAL INTAKE PHONE</b> <b>803.999.1750</b>	 <p>Access Intramed Plus prescription order forms here.</p>
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