INTRAMED Plus
infusion services

SKYRIZI®

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

Patient
Weight: _____ lbs.
Height: _____ 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 2 hours 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 #: _____

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	CENTRAL INTAKE PHONE **803.999.1750**	Access Intramed Plus prescription order forms here.