Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Risankizumab-rzaa (Skyrizi) Orders

Name: ___________________________________ DOB: ___________________________

Diagnosis/Indication: _________________________ ICD-10 Code: ______________________

1. Dosing Regimen:
   Crohn's Disease:
   Initial Dose:
   - ☐ Infuse Skyrizi 600 mg in dextrose 5% intravenously over 1 hour every 4 weeks x 3 doses (at weeks 0, 4, and 8). Dilute in 100 mL, 250 mL, or 500 mL of 5% dextrose for a final concentration of 1.2 to 6 mg/mL

   Maintenance Dose starting at Week 12 (select one):
   - ☐ Followed by Skyrizi 180 mg SQ every 8 weeks, **patient to self-administer**
     - ☐ Teaching to occur by infusion RN (provider's office to arrange patient receiving medication)
   - ☐ Followed by Skyrizi 360 mg SQ every 8 weeks, **patient to self-administer**
     - ☐ Teaching to occur by infusion RN (provider's office to arrange patient receiving medication)
2. Vital signs: Initial, PRN
3. Pre-medications to be given 30 minutes prior to infusion (optional)
   - ☐ OMG Infusion Center Pre-Medication Protocol

   OR
   - ☐ Administer the following routine pre-medications prior to each infusion
     - ☐ Acetaminophen (Tylenol) 650 mg PO
     - ☐ Antihistamine (Select one)
       - ☐ Diphenhydramine (Benadryl) 25 mg PO
       - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
       - ☐ Loratadine (Claritin) 10 mg PO
     - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
     - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
     - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV
   - ☐ Other: ____
4. For infusion reaction (**Must select one to be considered a complete order**)
   - ☐ Acute Infusion Reaction Protocol
   - ☐ Other ____

Obtain liver enzymes and bilirubin levels prior to initiating treatment and during induction (at least up to 12 weeks of treatment). Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: ______________________________________ Date: ____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: ___________________________________ Time: ___________

Patient Name: ____ DOB: ____________