HOME INFUSION OPTIONS PH:800.996.0978 | FX: 800.430.2202

SKYRIZI (risankizumab-rzaa)Infusion Order

Patient Name:_____

DOB: _____ Phone:_____

*** Include facesheet with demographics and Insurance ***

DIAGNOSIS: _____ ICD-10: _____

*** Include H&P, clinical notes and labs to support diagnosis ***

PRE-MEDICATION - *30 min prior to administration*

- ○ Acetaminophen (Tylenol) 650mg PO
- ○ Diphenhydramine 25mg PO
- ○ Solu-Medrol 125mg IVP
- ○ Diphenhydramine 25mg IVP

SKYRIZI IV INFUSION ORDERS

DOSAGE

- ○ 600 mg *flat dosed*
- ○ *Administer 600mg intravenous infusion on week 0, 4, 8*
- ○ 360 mg OBI *Week 12 and every 8 weeks for maintenance*

PATIENT WEIGHT

_____ lb / kg

SKILLED NURSING

- ○ Per Administration

REFILLS: _____

Infusion supplies are authorized to be dispensed per pharmacy protocol and medication administration guidelines
Hypersensitivity / Anaphylaxis Reaction per pharmacy protocol (reverse)

LABS - ***Please attach labs, including LFT, Bilirubin and TB results from the previous 6 months***

- ◉ LFT to be drawn between weeks 4-8 of Induction therapy
- ○ Requested Labs and Frequency_____
- ○ No Labs Requested

PRIOR THERAPIES TRIED AND FAILED

_____

○ Unresponsive to Conventional Treatment ○ Inadequate Response to Methotrexate (Dose:_____)

ORDERING PROVIDER

Signature:_____ Date: _____

Provider: _____ NPI: _____

Phone: _____ Fax: _____

HOME INFUSION PROTOCOL DISCLAIMER

** **THIS FORM MUST BE INITIALED AND RETURNED WITH PRESCRIPTION** **

ATTENTION PROVIDER:

Prior to signing orders, you will need to define the dose, interval, and the number of treatments. Tri-Unity Infusion Services will follow a flat dose or dose by weight, as specified on the prescription. Tri-Unity Infusion Nursing Staff will initiate **Peripheral Intravenous (PIV) access** for the administration of ordered medication, unless specified on prescription to administer previously placed PICC line or Port-a-cath. Tri-Unity Infusion Services will forward nursing administration notes to the provider following the infusion.

LABS REQUIRED (within the last 6 months):

- Negative TB screening prior to initiating Entyvio, Remicade, Skyrizi
- Negative HBV prior to starting Remicade
- LFT panel and Bilirubin prior to beginning Skyrizi
- Additional LFT Panel to be drawn between weeks 4-8 after starting Skyrizi

PRE-MEDICATIONS

- Acetaminophen (Tylenol) 650 mg, PO, Once. Administer 30 minutes prior to infusion
- Diphenhydramine (Benadryl) 25 mg, PO, Once. Administer 30 minutes prior to infusion

PRN MEDICATIONS

- Acetaminophen (Tylenol) 650 mg PO, Every 4 hours, PRN for mild pain, fever
- Diphenhydramine (Benadryl) 25 mg IVPush, Every 4 hours, PRN for itching, urticaria, pruritus, or shortness of breath

ANAPHYLAXIS REACTION/HYPERSENSITIVITY

- Diphenhydramine (Benadryl) 25 mg IVPush, PRN for Hypersensitivity Reaction or itching. May repeat Once if symptoms persist after 30 minutes
- Epinephrine (Adrenaline) 0.3 mg, 1:1000, Sub-Q, Once, PRN for Anaphylaxis or Severe Bronchospasm. **911 WILL BE CALLED AND PHYSICIAN WILL BE NOTIFIED**
- Hydrocortisone sodium succinate PF (Solu-Cortef) 100 mg IVPush, Once, PRN for Hypersensitivity Reaction, itching, rash, hives, and/or shortness of breath
- Sodium Chloride 0.9% IV Bolus 250 mL over 15 minutes Once, PRN for Hypersensitivity and/or Anaphylaxis Reaction

TITRATION

Ambulatory Infusion Pump will be titrated by the Pharmacist in Charge as instructed on medication package insert, unless otherwise noted on prescription.

PROTOCOL CONFIRMED BY PRESCRIBING PHYSICIAN _____

INITIAL