

## Community Health Interventions Specialty Clinic

### INFUSION ORDERS- SKYRIZI® (risankizumab)

PATIENT INFORMATION				
Name:			DOB:	
Allergies:			Date of Referral:	
REFERRAL STATUS				
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency		<input type="checkbox"/> Order Renewal
DIAGNOSIS AND ICD 10 CODE				
<input type="checkbox"/> Plaque Psoriasis	ICD 10 Code: L40.0	<input type="checkbox"/> Crohn's	ICD 10 Code: K50.90	
<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: L40.50			
REQUIRED DOCUMENTATION/Testing				
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance info			<input type="checkbox"/> Clinical/Progress notes supporting primary dx <input type="checkbox"/> Confirmed negative TB testing <input type="checkbox"/> LFT and Bilirubin prior to each dose for Crohn's week 12 and PRN thereafter	
List Tried & Failed Therapies, including duration of treatment:				
1)		2)		
MEDICATION ORDERS				
Premedication				
Biologic Injection/Infusion Order				
Medication	Dosing/Diluent	Route	Rate of infusion	Dates of administration
<input type="checkbox"/> Skyrizi for Plaque Psoriasis	150mg/ml prefilled syringe	SQ	N/A	Week 0 _____
<input type="checkbox"/> Skyrizi for Psoriatic Arthritis	150mg/ml prefilled syringe	SQ	N/A	Week 4: _____ Every 12 Weeks starting: _____
<input type="checkbox"/> Skyrizi for Crohn's induction	600mg mixed in D5W as per pharmacy	IVPB	1 hour	Week 0: _____ Week 4: _____ Week 8: _____
<input type="checkbox"/> Skyrizi for Crohn's maintenance	360mg/2.4ml prefilled cartridge	SQ	N/A	Week 12 from induction: _____ Every 8 weeks after Week 12 starting: _____
OTHER ORDERS				
Hold treatment if the patient has any infections prior to infusion				
PHYSICIAN INFORMATION				
Prescribing Physician:				
Office Contact Name:				
Office Phone:		Office Fax:		Office Email:
Physician Signature:				Date:

**Contact us with questions at: [jeff@eastoninfusion.com](mailto:jeff@eastoninfusion.com) or call 728-777-5546**

Fax completed form and all documentation to **(561) 709-8626**

All information contained in this form is strictly confidential and will become part of the patient's medical record.