MIC | METRO INFUSION CENTER

INFUSION ORDERS- SKYRIZI® (risankizumab-rzaa)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE			
☐ Plaque Psoriasis	ICD 10 Code: L40.0	☐ Crohn's Disease	ICD 10 Code: K50.90
☐ Psoriatic Arthritis	ICD 10 Code: L40.50		

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info	☐ Clinical/Progress notes supporting primary dx ☐ Confirmed negative TB testing ☐ LFT and Bilirubin prior to each dose for Crohn's up to 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
☐ Skyrizi for Plaque Psoriasis	150mg/ml prefilled syringe	SQ	N/A	Week 0_____ Week 4: _____ Every 12 Weeks starting: _____
☐ Skyrizi for Psoriatic Arthritis	150mg/ml prefilled syringe	SQ	N/A	
☐ Skyrizi for Crohn's induction	600mg mixed in D5W as per pharmacy	IVPB	1 hour	Week 0: _____ Week 4: _____ Week 8: _____
☐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:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164