INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Skyrizi *risankizumab-rzaa*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Crohn's Disease, ICD 10: K50.
☐ Ulcerative Colitis, ICD 10: K51.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB screening
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Skyrizi	Crohn's: 600 mg Ulcerative colitis: 1,200 mg	IV	Weeks 0, 4, 8
	Then maintenance dosing: ☐ 180 mg or ☐ 360 mg	Subcutaneous inj.	Week 12, then every 8 weeks

x3 IV infusions need to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____