

Risankizumab (Skyrizi) Induction ORDER FORM



REQUIRED DOCUMENTATION attached:

- ☐ H&P completed within last year.
- ☐ Documentation supporting diagnosis and prior therapies for diagnosis.
- ☐ Documentation of hepatitis B vaccination or testing.
- ☐ Documentation of tuberculosis (TB) testing – PPD or Quantiferon testing. Date of negative test _____
- ☐ Patient is brought up to date with all immunizations before starting therapy.
- ☐ List of current medications and allergies.

Diagnosis: Patient weight _____ kgs Height _____ inches

- ☐ Crohn's disease ☐ Plaque psoriasis
- ☐ Ulcerative colitis ☐ Psoriatic arthritis

ORDERS

1. PPD or Quantiferon before start of therapy if none in past 12 months. Notify provider of positive results.
2. Complete Blood Count with Auto Diff (CBC); complete metabolic panel (CMP); C-reactive protein (CRP), if none in past 30 days.
3. Serologic testing for **Hepatitis B** virus (Hepatitis B Surf Ag w/Rfx Conf, Hepatitis B Surface Antibody, Hepatitis B Core Ab Total) and **Hepatitis C** virus (Hep C Ab, Rfx Quant w/Genotype), **HIV** Antigen/Antibody 4th Gen.
4. Pregnancy test if between 14 and 50 years old with gestational potential.
5. Assess patient prior to each treatment for signs of infection or malignancy (especially skin cancer) or recent vaccinations.
Hold treatment and notify provider if symptoms of uncontrolled serious infections or live vaccines administered within 4 weeks of starting therapy.
6. Provide FDA medication guide prior to first dose.
7. **TREATMENT: Risankizumab at 0,4 and 8 weeks**
☐ **600 mg IV in Sodium Chloride 0.9% 100 mL** infused over 1 hour.
☐ **1200 mg (Ulcerative colitis only) IV in sodium chloride 0.9% 250 ml**, infused over 2 hours.
8. Anaphylaxis kit in unit and initiate per anaphylaxis policy if signs and symptoms of allergic reactions.
10. Vital signs pre and post infusion. Patient may be discharged if post-infusion vital signs are stable.
11. Educate patient about signs and symptoms of severe infections, and malignancy (especially skin cancer). Patient should expect to start self-injection with subcutaneous formula 4-weeks after last infusion. Offer education on subcutaneous injections, sharps container and proper disposal if not provided by prescribing office.

REQUIRED Prior Authorization Number: _____ [] pending [] Complete [] not needed*

*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date: _____ Time: _____ Name: _____

Checklist for non-RFGH credentialed providers:

- ☐ Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist. Contacted provider: _____
- ☐ Problem list & medication list attached to orders.

FAX to RFGH Infusion clinic at 207-858-2404

Contact Infusion Clinic at 207-858-8722

Provider signature _____ Date _____ time _____

If not RFGH credentialed: Printed name _____ Phone # _____

RFGH Co-signature _____ Date _____ time _____

Printed name _____

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Originator: Pharmacy

Label or
Patient name _____

Date of birth _____

Patient phone number _____