Provider Order Form

SKYRIZI (RISANKIZUMAB-RZAA)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Plaque Psoriasis L40. _____ ☐ Crohn's Disease K50. _____

☐ Psoriatic Arthritis L40. _____ ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Skyrizi (Risankizumab-Rzaa), IV	☐ 600 mg	☐ Induction: Week 0, Week 4, and Week 8
☐ Skyrizi (Risankizumab-Rzaa), Subcutaneous Injection	☐ 180 mg ☐ 360 mg	☐ Maintenance: Week 12 and every 8 weeks thereafter
☐ Skyrizi (Risankizumab-Rzaa), Subcutaneous Injection	☐ 150 mg	☐ Induction: Week 0, Week 4, and every 12 weeks thereafter ☐ Maintenance: Every 12 weeks

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Infuse over at least 60 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____

☐ Other _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Liver enzymes and Bilirubin

Provider Signature _____ Date _____