Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Skyrizi (risankizumab-rzaa)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg _____ lb	Patient Height: _____ in

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

Location Preference (optional)
☐ Richmond ☐ Prince George

If patient has a central line, then the placement report, diagnostic imaging to confirm tip placement and date of last access are required

DIAGNOSIS AND ICD-10 CODE	
☐ Moderate to Severe Crohn's Disease	K50.90
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
☐ This signed order form by the provider	☐ Clinical/Progress Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ HBVPanel results (required by some insurances)	☐ QuantiFERON Gold TB Test Results
☐ Baseline Liver Function Tests (AST/ALT)	
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	3)
2)	4)

MEDICATION ORDERS	
Initial Dosing (for Crohn's Disease)	☐ Skyrizi 600mg infuse IV over 1 hour at weeks 0, 4 and 8
Maintenance Dosing**	☐ Skyrizi 180mg SQ On-Body Injector at week 12, then every 8 weeks**
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____	

**If prescriber chooses to provide a maintenance order to Infusion Solutions, we will ask insurance provider IF Infusion Solutions can provide. However, many carriers require Speciality Pharmacy Networks for the SQ On-Body Injector and Infusion Soltutions is UNABLE to assist. Prescriber will be notified promptly if this is the case.

OPTIONAL PREMEDICATIONS and LAB ORDERS
☐ Acetaminophen 650mg PO prior to infusion and/or injection
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion and/or injection
☐ Methylprednisolone 40mg slow IVP prior to infusion
☒ RECOMMENDED for Crohn's Disease: CMP Lab order at week 8 dose to check AST/ALT
☐ Other PreMed or Lab Order with frequency:_____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.