



### Checklist for Skyrizi (risankizumab-rzaa) Referral

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ NPI: \_\_\_\_\_

Office Contact/Title/Email: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Best contact number for physician in case of reaction: \_\_\_\_\_

*Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.*

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). \*Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Skyrizi
  - Medication list and allergies
- Supporting lab reports/imaging for Skyrizi IV Induction treatment
  - Baseline negative TB screening
  - Baseline liver enzymes and bilirubin levels
- Skyrizi Prescribing Order (see attached)

**-- We will obtain prior authorization and schedule your patient as soon as possible --**

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**Fax all information to our Infusion Coordinator: 508-698-8671**

Call with any questions: 781-551-5812 option 4

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Visit our website: [www.InfusionCenterNE.com](http://www.InfusionCenterNE.com)

Email: [info@infusioncenterne.com](mailto:info@infusioncenterne.com)



### Prescribing Order: Skyrizi (risankizumab-rzaa) IV Induction

Date of Order: \_\_\_\_\_

New Start    Maintenance  
Date of last injection: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F: \_\_\_\_\_

Diagnosis (include ICD-10 code/s): \_\_\_\_\_

NKDA      Allergies: \_\_\_\_\_

**Premedication:**

- Acetaminophen 1000mg PO       Diphenhydramine 25mg PO  
 Loratadine 10mg or Cetirizine 10mg PO       Other: \_\_\_\_\_

**Skyrizi Medication Order – Induction Dosing**

- Dosing:       Skyrizi 600mg IV over 1 hour (Crohn's disease)  
 Skyrizi 1200mg IV over 2 hours (ulcerative colitis)
- Frequency:     Week 0, Week 4, and Week 8

**Administration:**

- ✓ Administer Skyrizi IV in 250ml 5% Dextrose or 0.9% Sodium Chloride over 1-2 hours per indication
- ✓ Do not administer if patient has active signs or symptoms of infection or hepatic dysfunction.
- ✓ In case of reaction, follow ICNE infusion reaction protocol. Notify physician.

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Ordering Provider Name

NPI

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Signature

Date