ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Allenmore Infusion Services - Fax: 253-864-4052
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Risankizumab (Skyrizi)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Crohn's Disease

ICD -10 Code:
❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation.
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- CBC, CMP
- Latent TB testing, Date: _____ / _____ / _____ Results: _____
- HBV screening, Date: _____ / _____ / _____ Results: _____
- HCV screening, Date: _____ / _____ / _____ Results: _____
- HIV screening, Date: _____ / _____ / _____ Results: _____

*Patients should be up to date with all immunizations before initiating therapy. Avoid the use of live vaccines in patients undergoing Risankizumab treatment

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen:

❑ Risankizumab (Skyrizi) 600 mg IV infusion over 1 hour at week 0, 4 and 8
❑ Risankizumab (Skyrizi) 360 mg SUBQ at week 12 then every 8 weeks thereafter
****Medicare will not cover SUBQ in outpatient setting**

☑ **Vital Signs:** Check vital signs prior to and at compeltion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP<90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Order expires in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
CROHN'S DISEASE

MultiCare

60-0191-6 (9/22)