ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

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

❑ Ulcertive Colitis

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 for Risankizumab (Skyrizi) dose:

❑ Crohn's Disease - 600 mg IV infusion over 1 hour at week 0, 4, and 8.

❑ Ulcerative Colitis - 1200 g IV over 2 hours at week 0, 4, and 8.

Maintenance dose for both: 180 pr 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.

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 (Rev. 9/24)