MHS Home/Alternate Site Infusion Services
Risankizumab-rzaa (Skyrizi) Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	
Patient Allergies:		

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline labs required:

- CBC, CMP Date: _____/_____/_____ Result: _____
- Latent TB testing Date: _____/_____/_____ Result: _____
- HBV Screening Date: _____/_____/_____ Result: _____
- HCV Screening Date: _____/_____/_____ Result: _____
- HIV Screening Date: _____/_____/_____ Result: _____

Lab Orders: _____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

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

Provider Order for Risankizumab-rzaa (Skyrizi) Infusion

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

Medication:

Crohn's Disease:

- ☐ Risankizumab-rzza (Skyrizi) 600 mg IV in 100 mL NS over at least 1 hour at week 0, 4, and 8
- ☐ Risankizumab-rzza (Skyrizi) 180 mg SQ at week 12, then every 8 weeks thereafter *OR*
- ☐ Risankizumab-rzza (Skyrizi) 360 mg SQ at week 12, then every 8 weeks thereafter

Ulcerative Colitis:

- ☐ Risankizumab-rzza (Skyrizi) 1200 mg IV in 250 mL NS over at least 2 hours at week 0, 4, and 8
- ☐ Risankizumab-rzza (Skyrizi) 180 mg SQ at week 12, then every 8 weeks thereafter *OR*
- ☐ Risankizumab-rzza (Skyrizi) 360 mg SQ at week 12, then every 8 weeks thereafter

Additional Medications:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

Skilled Nurse Interventions:

- Admit *(first visit)* patient to services for home/alternate site infusion therapy of Risankizumab-rzza (Skyrizi).
- Complete Skilled Nurse visit with each infusion/injection for ongoing home/alternate site infusion/injection therapy of Risankizumab-rzza (Skyrizi).
- Obtain vital signs (TPR & B/P) at baseline of infusion/injection and at completion of infusion.
- Obtain patient weight at each visit.

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification: Name: MRN: DOB:	Pre-printed order – Page 1 of 2 Risankizumab-rzaa (Skyrizi) MultiCare

Skilled Nurse Interventions (continued):

- For Infusions:
  - Establish IV access and flush per policy to maintain patency.
  - Draw labs as ordered.
  - Withdraw ordered volume of Risankizumab-rzza (Skyrizi) and add to appropriate-sized bag of 100 mL sodium chloride 0.9% (NS).
  - Infuse Risankizumab-rzza (Skyrizi) as prescribed.
  - Once infusion complete, flush IV line with sodium chloride 0.9% (NS) as prescribed.
  - If vital signs are stable after infusion and any observation period, Skilled Nurse will discontinue IV access and complete visit.
- For SubQ injections:
  - Inject Risankizumab-rzza (Skyrizi) as ordered.
  - Evaluate patient for ability to self-inject Risankizumab-rzza (Skyrizi). If patient/caregiver deemed appropriate for self-injection, contact provider for additional orders.
  - If patient remains stable, Skilled Nurse will complete visit

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (*below*).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available. Max dose = 50 mg.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Site Infusion Services 253-459-6650 *(phone)* / 253-864-2785 *(fax)*
Phone #: _____ Fax#: _____	

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:	Pre-printed order – Page 2 of 2
Name:	Risankizumab-rzza (Skyrizi)
MRN:	MultiCare Revised 10/24
DOB:	