

McLeod Health

Place Sticker Here

Risankizumab (Skyrizi) Treatment Plan for Gastroenterology

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

- K50.0__ Crohn's Disease (small intestine) K50.8__ Crohn's Disease (small and large intestine)
- K50.1__ Crohn's Disease (large intestine) K51.0__ Ulcerative (Chronic) Pancolitis
- K51.2__ Ulcerative (Chronic) Proctitis K51.3__ Ulcerative (Chronic) Rectosigmoiditis
- Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

- None
- Acetaminophen 650 mg PO
- Diphenhydramine: Dose: 25 mg 50 mg Route: PO or IVP
- Methylprednisolone: Dose: 40 mg or 125 Route: IVP
- Famotidine: Dose: 20 mg Route: PO or IVPB
- Other (include drug, dose, and route): _____

Drug Orders:

- Rizankizumab (Skyrizi) (J2327) per 250 mL Sodium Chloride 0.9% IV to infuse IV over 1-2 hours

Dose: Crohn's Disease: 600 mg over 1 hour
 Ulcerative Colitis: 1200 mg over 2 hours

Frequency: Weeks 0, 4, and 8
 Other: _____

- Subcutaneous maintenance dosing to be initiated by physician office starting at Week 12 every 8 weeks thereafter

Lab Orders:

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received risankizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____
and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-6195 (Phone)