McLeod Health

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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.

Seacoast: 843-366-2830 (Fax)

843-390-8200 (Phone)