WEST TEXAS
DIGESTIVE DISEASE CENTER

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Gastroenterology
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South Plains
Infusion

# SKYRIZI (risankizumab-rzaa) infusion orders

Name:_____ DOB:_____ M ○ F ○

Phone #1 :_____(H/W/C) Phone #2:_____(H/W/C)

Allergies:_____

Diagnosis: Please provide ICD-10 code

○_____Crohn's Disease ○_____(other)

Pre-medication

○ Tylenol 1000mg PO
○ Diphenhydramine 25 mg PO
○ Cetirizine 10mp PO
○ _____

○ Solu-Medrol 125mg IVP
○ Solu-Cortef 100mg IVP
○ Diphenhydramine 25mg IVP
○ _____

## SKYRIZI ORDERS

☐ Induction Dose: Infuse 600mg over at least 1 hour at week 0, week 4, and week 8.

☐ Maintenance dose: 180mg subcutaneously at week 12, then every 8 weeks thereafter x 1 year

☐ Maintenance dose: 360mg subcutaneously at week 12, then every 8 weeks thereafter x 1 year

PATIENT WEIGHT
_____ lbs.
_____ kg

**NOTES**

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## ORDERING PROVIDER

Signature X_____ Date_____

Provider _____ Phone _____ Fax_____

Please FAX: ○Medication Order ○Demographics ○Clinicals ○Labs ○X-Rays
to 1-806-302-1241 (must dial "1")