Risankizumab-rzaa (Skyrizi IV)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Baseline Liver Enzymes and Bilirubin • Negative TB results: If results are positive, provide doc. of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ K50.00 Crohn's disease of small intestine without complications	☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K50.10 Crohn's disease of large intestine without complications	☐ K51.80 Other ulcerative colitis without complications
☐ K50.90 Crohn's disease, unspecified without complications	☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other:	

PRIMARY MEDICATION ORDER

Risankizumab-rzaa (Skyrizi) induction, Intravenous

• Flush with 0.9% sodium chloride at infusion completion

• Provider's office is required to coordinate maintenance Subq doses

☐ Patient is required to stay for 30-minute observation

☐ **Crohn's Disease:** induction 600mg IV at Weeks 0, 4, and 8

☐ **Ulcerative Colitis:** induction 1200mg IV at Weeks 0, 4, and 8

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Skyrizi

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772