

Risankizumab-rzaa (Skyrizi IV)

Provider Order Form rev. 8/24/26



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