Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Risankizumab (Skyrizi) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.

-Sign, date and fax to: 904-296-9070

General Information							
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____	

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Chrone's Disease ☐ Other: _____	☐ K50.____ ☐ Other: _____	☑ J3590	☑ CPT Code: _____

Labs (prior to scheduling infusion)	Other Labs:
☑ CBC with differential, CMP, Bilirubin, TB skin test, Hepatitis B virus screening, Hepatitis C virus screening, HIV screening	☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Risankizumab	IV	600 mg *over at least 60 mins*	Once	☐ Induction: Week 0, 4, and 8 (total 3 doses) ☐ Other: _____ for ____ dose(s)

Order Comments: Protect from light. Mix in D5W to final concentration 1.2 mg/mL - 6 mg/mL.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to:	Fax Number _____

Provider Signature		Date	
Provider Printed Name			