Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Office: 212-803-3339 Fax : 646-768-8600

Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Manhattan
225 East 70th Street
New York, NY 10021

Holbrook/ Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

Long Beach
917 Beech Street
Long Beach, NY 11561

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Risankizumab-rzaa (Skyrizi)

Provider Order Form

Date: ____________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every ____________________
- ☐ CMP ☐ at each dose ☐ every ____________________
- ☐ Hepatic Function Panel ☐ at each dose ☐ every ____________________
- ☐ Other: ____

PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
- ☐ Other: ____

Dose: ____________________ Route: ____________________

Frequency: ____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- ☐ **Risankizumab-rzaa** (Skyrizi) Induction IV dose
  - Dose: 600mg
  - Frequency: week 0, week 4, and week 8
  - Route: Intravenous
  - Infuse over 60 minutes
- ☑ Flush with 0.9% sodium chloride at the completion of infusion
- ☐ Other ____________

- ☐ Patient required to stay for 30-min observation post procedure
- ☐ Patient is NOT required to stay for observation time
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ____________________

(if not indicated order will expire one year from date signed)

Total Doses:

- ☐ Year__________
- ☐ Other__________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X ____ Date ____________

Provider ________________________ Phone ____________ Fax ____________