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ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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 _____