Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Skyrizi (risankizumab-rzaa) Non-Oncology Treatment Order Set

1. Patient Name: ____

2. DOB: ______________________________________ **Height (inches):** __________ **Weight (lbs):** _______________

3. Diagnosis:

[ ] K50.0 – Crohn's Disease
[ ] Other ICD-10 Code: __________________ Diagnosis description: ___________________________

4. Pre-medications:

[ ] Other Pre-medication: ____
[ ] No Pre-medications indicated

5. Drug Order:

Skyrizi (risankizumab-rzaa) *Ok to substitute with generic/biosimilar*

[ ] Induction: 600mg IV weeks 0, 4, and 8

Special Instructions: ____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received ___________________ Next Dose Due __________________

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] Other: ____
[ ] No labs monitoring

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Baseline Lab/Testing completed:

[ ] Liver Enzymes and Bilirubin, date: _______ [ ] CBC/CMP, date: _________ [ ] TB status, date: ________
[ ] Hepatitis B Panel, date: ________ [ ] Other:__________

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in COMPLETE program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: ____ **Phone:** ________________
Physician's Signature: ____**Date:** _______________

(This drug administration order form is valid for 12 months)