

(risankizumab-rzaa)

SKYRIZI Infusion Orders



Patient Name _____ DOB _____ Gender: M F

Phone _____

DIAGNOSIS: *Please provide IDC-10 Code*

- _____ Psoriatic Arthritis
- _____ Plaque Psoriasis
- _____ Crohn's Disease

PRE-MEDICATION:

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input checked="" type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ Other | <input type="checkbox"/> _____ Other |

SKYRIZI ORDERS:

DOSAGE:

- 600mg (flat dose) IV**
- Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy*

PATIENT WEIGHT

(Current, but weigh each visit)
_____ LBS
_____ KG

FREQUENCY:

- Give 600mg IV at Weeks 0, 4, and 8 then patient to begin self administration subcutaneous injections at home**
- Other _____ IV then patient to begin self administration subcutaneous injections at home**
-

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Establish and maintain IV access / may use central venous access if appropriate and maintain per Specialty Infusion Center policy
- Flush IV with 3ml-5ml of saline before and after every IV medication and PRN
- Administer infusion medication/injection as ordered
- If mild itching, slow down the infusion and monitor patient closely
- If anaphylactic reaction, stop infusion, implement emergency medications, and plan and call 911
- When infusion complete, flush IV with 3ml to 5ml saline flush or 50ml bag of saline and discontinue IV per INS Standards
- Evaluate effectiveness of infused therapy on disease process
- Lab work per physician when ordered

ORDERING PROVIDER:

Signature _____ Printed Name: _____ Date _____

Practice _____ Phone _____ Fax _____

*****PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058*****