St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Risankizumab-rzaa (Skyrizi)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note**.**
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
3. Risankizumab-rzza may increase the risk of infection. Instruct patient to inform healthcare provider if they develop any symptoms of an infection. Treatment should not be initiated or continued in patients with any clinically important active infection until the infection is resolved or treated.
4. Patient should be brought up to date with all immunizations before initiating therapy. Live vaccines should not be given concurrently.
5. Monitor liver enzymes and bilirubin levels at baseline and during induction, up to at least 12 weeks of treatment.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

☐ CMP, Routine, ONCE, every visit
☐ CBC auto differential, Routine, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. Monitor for signs and symptoms of infection. Advise patient to report symptoms of infection.
3. For signs and symptoms of active infection contact provider prior to administering.
4. Vital signs before infusion then PRN

5. IV Access: Peripheral IV site with saline lock. May use existing PICC line or port-a-cath if available.

MEDICATIONS:

Induction:

risankizumab-rzaa (SKYRIZI), ONCE, every 4 weeks x 3 doses (Week 0, Week 4, & Week 8)

☐ Crohn's Disease – 600 mg in dextrose 5%, intravenous, over 1 hour

☐ Ulcerative Colitis – 1200 mg in dextrose 5%, intravenous, over 2 hours

Maintenance:

GUIDELINE FOR ORDERING – Subcutaneous injections are included on the Center for Medicare & Medicaid Services Self-Administration Drug Exclusion List. An outpatient prescription for subcutaneous maintenance dosing will need to be supplied by the provider for patients with traditional Medicare (Medicare A/Medicare B) for self-administration.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

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ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed