



**Atrium Health Infusion  
Center**

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Pineville <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Southpark <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Huntersville <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC <b>Fax: 704-512-5390</b> <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC <b>Fax: 704-512-5390</b> <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC <b>Fax: 704-512-5390</b>

**Skyrizi® (Risankizumab-rzaa) Infusion Order (11/4/2025)**

All orders with a √ will be placed.

<b>Patient Demographics:</b>	
Patient Name:	Date of Birth:
MRN:	
Address:	
City:	State:
Zip Code:	
Allergies: (please list all allergies or attach list)	
<input type="checkbox"/> NKDA	
<b>Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)</b>	
<input type="checkbox"/> K50.0___ - Crohn's disease (small intestine)	<input type="checkbox"/> K50.1___ - Crohn's disease (large intestine)
<input type="checkbox"/> K50.8___ - Crohn's disease (small & large intestine)	<input type="checkbox"/> K50.9___ - Crohn's disease, unspecified
<input type="checkbox"/> K51.0___ - Ulcerative (Chronic) pancolitis	<input type="checkbox"/> K51.2___ - Ulcerative (Chronic) proctitis
<input type="checkbox"/> K51.3___ - Ulcerative (Chronic) rectosigmoiditis	<input type="checkbox"/> K51.4___ - Inflammatory polyps of colon
<input type="checkbox"/> K51.5___ - Left sided colitis	<input type="checkbox"/> K51.8___ - Other Ulcerative colitis or unspecified
<input type="checkbox"/> Other:	
<b>Required Documentation: (required prior to scheduling )</b>	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs ( <i>must include labs pertinent to medication ordered</i> )	<input type="checkbox"/> No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	
Diagnostic Studies Pertinent to Medication Ordered	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request. <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Treatment Parameters:</b>	
Hold treatment and notify provider IF: <input checked="" type="checkbox"/> - Temperature is GREATER THAN 100oF; <input checked="" type="checkbox"/> - Patient complains of symptoms of acute viral or bacterial infection; <input checked="" type="checkbox"/> - Patient is taking an antibiotic for current infection.	
<input checked="" type="checkbox"/> Required Lab Results: Quantiferon Gold and Hepatic Function Panel PRIOR to FIRST treatment ( <b>Fax labs with order</b> )	
Hold Tx and Notify Provider IF: <input checked="" type="checkbox"/> - Quantiferon Gold: POSITIVE result, OR not on file; <input checked="" type="checkbox"/> - Hepatic Function Panel is abnormal OR not on file.	
<b>Nursing Communication:</b>	
<input checked="" type="checkbox"/> Start PIV/Access CVC and flush device per approved Atrium Health protocol.	
<input checked="" type="checkbox"/> Obtain vital signs PRE-treatment and POST-treatment and PRN during the treatment.	
<input checked="" type="checkbox"/> Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.	
<b>Pre-Medications: (Administer all pre-medications 30mins prior to treatment)</b>	
<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE	
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg PO ONCE	
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV ONCE	
<input type="checkbox"/> Loratadine (Claritin) 10mg PO ONCE	
<input type="checkbox"/> Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE	
<input type="checkbox"/> Hydrocortisone sodium succinate (Solu-Cortef) injection 100mg IV ONCE	
<b>Infusion Therapy:</b>	
<input checked="" type="checkbox"/> Risankizumab-rzaa (Skyrizi) Week 0, Week 4, and Week 8	
<input type="checkbox"/> Risankizumab-rzaa (Skyrizi) 600mg IV over 1 hour (Crohn's Disease)	<input type="checkbox"/> Risankizumab-rzaa (Skyrizi) 1200mg IV over 2 hours (Ulcerative Colitis)
<b>Supportive Care Medications:</b>	
<input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). ONLY administer if not given as a premedication.	
<input checked="" type="checkbox"/> Sodium chloride (bolus) 0.9% bolus 500mL IV ONCE PRN dehydration.	
<input checked="" type="checkbox"/> Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting for 4 dose.	
<b>Hypersensitivity Protocol:</b>	
<input checked="" type="checkbox"/> Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.	
<b>Prescriber Information:</b>	
Provider Name:	Phone:
Practice Name:	Fax:
Address:	NPI:
City, State, Zip:	Office Contact:
	Office Contact Phone Number:
<b>Physician Signature: (Order expires 12 months from date of signature ) No Stamp Signatures Accepted</b>	
Signature:	Date: