Atrium Health Infusion Centers
Phone: 704-468-3400 Fax: 704-468-3401

Skyrizi Infusion Order

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: Prior to first infusion Hepatic Function Panel and Quantiferon Gold (If outside Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☒ Skyrizi (risankizumab-rzaa) **_600_** mg IV over 1 hour **ICD 10 code: _____**

Frequency: every 4 weeks x 3 (week 0, week 4, and week 8)

Pre-Meds: Administer 30 minutes prior to Skyrizi

☐ Acetaminophen _____ mg PO x 1

☐ Diphenhydramine _____ mg PO or _____ mg IV x 1 *(if applicable, only choose ONE)*

☐ Hydrocortisone _____ mg IV x 1

☐ Loratadine 10mg PO x1

☐ Methylprednisolone Sodium Succinate _____ mg IV x 1

PRN Meds:

☒ Ondansetron HCL 4mg IV every 3 hours PRN nausea/vomiting

Lab Orders:

- Draw Hepatic Function Panel prior to the week 8 infusion.

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Do not administer if a patient has a temperature greater than 100°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor for signs of reaction for 30 mins after completion of 1st infusion and PRN after remaining doses.

Physician Name: _____

Physician Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN:

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