VANCOUVER CLINIC®

ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER

Attn: Infusion department

NAME:
DOB:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Risankizumab-rzaa (Skyrizi®)

Weight:_____lb/kg Height:_____inch/cm

Diagnostic Code ICD-10:_____ Diagnosis:_____

□ Initial Consult

Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.

Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P or most recent chart note.
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

Pre-treatment labs

- CBC and differential (if not done within last 30 days)
- Quantiferon-TB (baseline)
- Liver enzymes and Bilirubin level

Monitoring labs

- Hepatic panel will be placed at the time of the first and second infusion to be drawn 4 weeks after each dose and prior to induction dose at week 4 and 8 – results to ordering clinician for evaluation; infusion will not be held pending evaluation.

MEDICATIONS:

Risankizumab-rzaa (Skyrizi®)

- □ Initial dosing: 600 mg in Dextrose 5% in Water 250 mL, intravenous, over 60 minutes, on week 0, 4 and 8.

Provider's signature: _____

Provider's printed name: _____**Date:**_____

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245