Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER
Risankizumab-rzaa (SKYRIZI)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

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

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. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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.

- ☐ risankizumab-rzaa (SKYRIZI), 360 mg, subcutaneous, ONCE at week 12 and every 8 weeks thereafter**.**

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756