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Troy, OH 45373
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Washington Township Infusion Center
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Skyrizi® (Risankizumab) Order Form

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Induction dosing:

Risankizumab 600 mg IV diluted in D5W (to a final concentration of 1.2-6 mg/mL) over 1 hour at weeks 0, 4, and 8

(Followed by home subcutaneous maintenance dosing at week 12 and every 8 weeks thereafter.)

Monitoring:

Last date and type of TB test: _____ (please fax copy of results with order)

Last date of hepatitis B & C panel: _____ (please fax copy of results with order)

Other Comments: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____