Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Skyrizi® (Risankizumab) Order Form

Patient Name: ____ **DOB:** ____________________

Address: ____

Phone: ________________________________ **ICD-10 Diagnosis:** _____________________

Induction dosing:

☐Risankizumab 600 mg IV over 1 hour at weeks 0, 4, and 8

☐Risankizumab 1200mg IV over 1 hour at weeks 0,4, and 8 (ulcerative colitis indication only)

(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: ____

**urine hCG screening will be completed onsite prior to treatment where appropriate

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:** _________________