

Troy Infusion Center
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Troy, OH 45373
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
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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 2 hours 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:** _____