BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height_____ Weight_____ Infusion Location: (state and site)_____

Skyrizi® (risankizumab-rzaa) Infusion Orders

Diagnosis: Please add ICD 10
_____ Crohn's Disease (This is the only diagnosis the IV is used for)

Nursing Orders:

-Hold treatment and notify provider for:

- Signs or symptoms of illness/active infection or recent live vaccinations
- Elevated LFTs or bilirubin

Documentation Needed:

- ☐ TB and Hepatitis B results
- ☐ CRP, ESR, LFTs & Bilirubin prior to start and every 8 weeks for the first 8 weeks of therapy
- ☐ Treatment failures
- ☐ Colonoscopy

Lab Orders:

☐ CBC w/diff, CMP, ESR, CRP, Bilirubin, LFTs every 4 weeks until after induction then every 12 weeks

☐ Other: _____

☐ Initial Dosing: 600mg IV over 1 hr at week 0, week 4 and week 8. Dilute in:

☐ D5W 100ml	☐ D5W 250ml	☐ D5W 500ml

Maintenance Dosing:(not done thru OI Infusion)

-If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

Additional Orders:

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 4/13/23 Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability