Skyrizi Order
(risankizumab-rzaa)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Medication List ☐ TB Labs

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS: *(usually not indicated)*

☐ Diphenhydramine	25mg	☐ PO	☐ IV	☐ Pre-med	☐ PRN
☐ Acetaminophen	650mg		PO	☐ Pre-med	☐ PRN

☐ Other OTC: _____

SKYRIZI (RISANKIZUMAB-RZAA) IV DOSING

For Crohn's Disease

600mg/250mL normal saline, Infuse over 1 hour

Induction Dose at 0, 4, and 8 weeks

Start Date of Infusion: _____