FUSIONDRIP
HYDRATION & WELLNESS

Skyrizi (risankizumab-rzaa) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continue **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ K50.90 – Crohn's disease, unspecified
☐ K50.80 – Crohn's disease of small and large intestine
☐ K51.90 – Ulcerative colitis, unspecified
☐ K51.01 – Ulcerative pancolitis with complications
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- **Induction Phase:**
  ☐ 600 mg IV at Weeks 0, 4, and 8 (Crohn's disease)
  ☐ 1200 mg IV at Weeks 0, 4, and 8 (Ulcerative colitis)
- **Infusion Duration:**
  ☐ 600 mg over ≥60 minutes
  ☐ 1200 mg over ≥120 minutes
- ☐ Maintenance: Subcutaneous dosing to begin at Week 12 per referring provider
- ☐ Flush with 0.9% sodium chloride post-infusion
- ☐ Observation: ☐ 30 minutes post-infusion
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☐ Fusiondrip Hydration & Wellness Center Protocol (fusiondriphydration.com)

☐ Other – please fax preferred reaction orders to 614-413-3877

☐ **Premedication (Recommended)**
☐ Acetaminophen: ☐ 500 mg ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 40 mg ☐ 125 mg ☐ IV
☐ Hydrocortisone: ☐ 100 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ Liver enzymes & bilirubin
☐ TB Screening (Quantiferon Gold or equivalent within 12 months)
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Week 4 ☐ Week 8 ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies, intolerance, or contraindications
☐ TB screening and liver function results

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____