Agile Infusion Services LLC
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SKYRIZI FOR CROHN'S DISEASE MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ Diagnosis

☐ K50.0_____ Crohn's disease of small intestine
☐ K50.1_____ Crohn's disease of large intestine
☐ K50.8_____ Crohn's disease of both sm and lg intest.
☐ K50.9_____ Crohn's disease unspecified

■ Details Needed for Approval

Please answer all questions and provide supporting documentation.

- Does the patient have active moderate-to-severe Crohn's Disease? _____
- Which conventional agent(s) has the patient tried (and for how long) without effective response? _____
- Which conventional agent(s) has the patient demonstrated an intolerance for (please specific reaction)? _____
- Which conventional agent(s) are contraindicated (please specify contraindication)? _____
- Does the pt. have enterocutaneous (perianal or abdominal) or rectovaginal fistulas?_____ *If Yes, please attach full details.*
- Has the patient had ileocolonic resection to reduce the change of CD recurrence? _____ *If Yes, please attach full details.*
- Has the patient tried any other biologic immunomodulator for CD? _____ *If Yes, please attach full details.*

■ Medication Order

☐ Skyrizi (Risankizumab-rzaa) 600mg by IV every 4 weeks for three (3) infusions.

Medication shall be added to a 250ml 5% Dextrose infusion bag. Do not shake the bag. Allow the bag to come to room temperature. Infuse over at least 1 hour. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

Note: Only IV starter doses are available at Agile Infusion. Continuing therapy with On-Body Injector is not available at Agile Infusion.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.