
 <p style="text-align: center;">Oregon Health & Science University Hospital and Clinics Provider's Orders</p> <div style="display: flex; align-items: center;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small; margin-right: 5px;">PO7071</div>  </div> <p style="text-align: center;">ADULT AMBULATORY INFUSION ORDER Risankizumab-rzaa (SKYRIZI) for Crohn's Disease Infusion</p> <p style="text-align: center;">Page 1 of 3</p>	<p>ACCOUNT NO. _____</p> <p>MED. REC. NO. _____</p> <p>NAME _____</p> <p>BIRTHDATE _____</p> <p style="text-align: right; font-size: small;"><i>Patient Identification</i></p>
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.	

Weight: _____ kg **Height:** _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
3. Risankizumab-rzaa may increase the risk of infection. Instruct patient to inform healthcare provider if they develop any symptoms of an infection. Treatment should not be initiated or continued in patients with any clinically important active infection until the infection is resolved or treated.
4. Patient should be brought up to date with all immunizations before initiating therapy. Live vaccines should not be given concurrently.
5. Monitor liver enzymes and bilirubin levels at baseline and during induction, up to at least 12 weeks of treatment.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- CMP, Routine, ONCE, every visit

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. TREATMENT PARAMETER – Hold treatment and contact provider for AST/ALT greater than 2 x ULN or total bilirubin greater than 2 x ULN.
3. Monitor for signs and symptoms of infection. Advise patient to report symptoms of infection.
4. For signs and symptoms of active infection contact provider prior to administering.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



Oregon Health & Science University
Hospital and Clinics Provider's Orders

ADULT AMBULATORY INFUSION ORDER
**Risankizumab-rzaa (SKYRIZI) for
Crohn's Disease**

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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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MEDICATIONS:

Induction:

- risankizumab-rzaa (SKYRIZI), 600 mg in dextrose 5%, intravenous, over 1 hour, ONCE every 4 weeks x 3 doses (Week 0, Week 4, & Week 8).

Maintenance:

- risankizumab-rzaa (SKYRIZI), 360 mg, subcutaneous, ONCE at week 12 and every 8 weeks thereafter.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____



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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

Beaverton

OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006

Phone number: 971-262-9000

Fax number: 503-346-8058

NW Portland

Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.

Portland, OR 97210

Phone number: 971-262-9600

Fax number: 503-346-8058

Gresham

Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030

Phone number: 971-262-9500

Fax number: 503-346-8058

Tualatin

Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062

Phone number: 971-262-9700

Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders