ADULT AMBULATORY INFUSION ORDER
Risankizumab-rzza (SKYRIZI) for Crohn’s Disease Infusion

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-rzza 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.
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.
MEDICATIONS:

**Induction:**

Risankizumab-rzza (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-rzza (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 (Policy 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 x1 dose for hypersensitivity or infusion reaction.
3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction.
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction.
5. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 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: __________________

ONLINE 10/2022 [supersedes 09/2022] PO-8157
OLC Central Intake Nurse:
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