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 (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: ___________________________
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

- **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

- **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

- **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](http://www.ohsuknight.com/infusionorders)