DEHESA DERMATOLOGY

Dehesa Dermatology
978 N. Temperance Ave. Clovis CA 93611
(P) 559.951.9000 (F) 559. 234.6334
https://dehesadermatology.com

SKYRIZI® (RISANKIZUMAB-RZAA) INJECTION / INFUSION ORDER

Patient Information

Patient Name: _____

DOB: _____

Patient Height: _____
Patient Weight (kg): _____

Address: _____
_____

Phone: _____

Diagnosis: _____
ICD-10 Code: _____

Attach:
☐ Patient demographics
☐ Copy (front & back) of insurance card(s)
☐ Most recent clinical notes

Required Screening / Baseline Evaluation (Results must accompany order)
☐ Tuberculosis Screening (QuantiFERON-TB Gold or TST)
☐ Hepatitis B Surface Antigen (HBsAg)
☐ Hepatitis B Core Antibody (Total Anti-HBc)
☐ Hepatitis C Screening
☐ Baseline CBC
☐ Baseline CMP

Medication Order
☐ SKYRIZI® (Risankizumab-rzaa) 150 mg subcutaneous injection
Dosing Regimen:
☐ 150 mg subcutaneous at Week 0
☐ 150 mg subcutaneous at Week 4
☐ Then every 12 weeks thereafter
☐ Other: _____

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IV Induction:
☐ SKYRIZI® _____ mg IV at Week 0
☐ SKYRIZI® _____ mg IV at Week 4
☐ SKYRIZI® _____ mg IV at Week 8

Maintenance:
☐ 180 mg subcutaneous every 8 weeks
☐ 360 mg subcutaneous every 8 weeks
☐ Other: _____

Pre-Medications
☐ None
☐ Acetaminophen 650 mg PO once
☐ Diphenhydramine 25–50 mg PO or IV once
☐ Methylprednisolone _____ mg IV once
☐ Other: _____

PRN / Emergency Medications
Administer per reaction protocol if clinically indicated:
☐ Diphenhydramine 25–50 mg PO or IV PRN
☐ Methylprednisolone 125 mg IV PRN
☐ Famotidine 20 mg IV PRN
☐ Epinephrine 0.3 mg IM PRN anaphylaxis
☐ Albuterol 2.5 mg nebulized PRN bronchospasm
☐ Normal Saline IV bolus PRN hypotension

Additional Instructions

Ordering Physician:

Printed Name: _____

Signature: _____Date: _____

Contact Person: _____

Phone: _____Fax: _____

FAX ORDER TO 559.234.633