Lake Charles Memorial Health System

1PO

PO_Skyrizi Order Set

Last Revised: 7/26/2024

Risankizumab (Skyrizi) Order Set:

Patient Name: _____ DOB: _____

Height: _____ Weight: _____(kg) Allergies: _____

Diagnosis:

____K50.___ Crohn's Disease ____K51.___ Ulcerative colitis ____Other (ICD-10 Code:_____

Orders for Outpatient Infusion:

- **Fax order to 337-430-6976 once medical prior authorization obtained**
- **Assign as Outpatient**
- **Criteria for Administration:**
  - A negative TB skin test or other appropriate documentation of TB status must be faxed to 430-6976 prior to scheduling of appointment for patient.
- **Nursing:** Confirm TB and hepatitis B status (or has received hepatitis B vaccination). Assess patient for active infection prior to initiation of therapy: notify MD if present.
- **Labs:** CMP at baseline and prior to every IV infusion
- **Premedications – Give 15 minutes prior to infusion**:
  ___ Acetaminophen 650 mg PO x 1 dose ___ methylPREDNISolone 125 mg IV x 1 dose
  ___ diphenhydrAMINE 25 mg PO x 1 dose ___ diphenhydrAMINE 25 mg IV x 1 dose
  ___ diphenhydrAMINE 50 mg PO x 1 dose ___ diphenhydrAMINE 50 mg IV x 1 dose
  ___ Other: _____
- **Risankizumab Induction Dosing**
  _____Crohns Disease: Risankizumab (Skyrizi) (J2327) 600 mg in D5W 100 ml IV over 60 minutes at weeks 0, 4 and 8 weeks.
  _____Ulcerative colitis: Risankizumab (Skyrizi) (J2327) 1200 mg in D5W 250 ml IV over 120 minutes at weeks 0, 4 and 8 weeks.
- **Severe Reactions:** Stop infusion, initiate anaphylaxis protocol and notify MD.
- **IV Line Care**:
  - Normal Saline 10 ml IV flush after each use
  - For implanted ports: Heparin 100 units/ml 5 ml IV flush after each use or prior to deaccessing
- Discharge when infusion complete

Physician Signature: _____ Date/Time:_____

Orders for Specialty Pharmacy – FOR specialty pharmacy use ONLY:

- **Fax order to 337-494-6536 (pharmacy will get prior authorization for pharmacy benefits)**
  Risankizumab (Skyrizi) On-Body Injector with prefilled cartridge - Choose one:
  (use lowest *effective* dose to maintain therapeutic response)
  ____ Inject 180 mg SUBQ into thigh or abdomen on week 12 and then every 8 weeks
  ____ Inject 360 mg SUBQ into thigh or abdomen on week 12 and then every 8 weeks
  Quantity: #1 Refills: _____

  ____ Generic substitution permitted ____ Dispense as Written

Physician Signature: _____ Date/Time:_____