GREATER BOSTON INFUSION CENTER
17/19 Kendrick St, Wrentham, MA 02093
P 774-581-0032 | F 774-581-0033

Skyrizi IV Induction - Referral Checklist

Referral packet checklist Complete this page and attach the supporting items below.

PATIENT & REFERRING PROVIDER

PATIENT NAME | DOB | DATE

REFERRING PROVIDER | NPI | DIRECT CONTACT / EXT.

OFFICE / PRACTICE | PHONE | FAX

EMAIL | URGENT CLINICAL CONTACT

REQUIRED REFERRAL PACKET

- [ ] Patient demographics and contact information
- [ ] Primary and secondary insurance information; front/back card copies
- [ ] Supporting clinical notes / office visits documenting Skyrizi IV Induction treatment plan
- [ ] Current medication list and allergies
- [ ] Relevant laboratory results / imaging and baseline safety information
- [ ] Completed Skyrizi IV Induction prescribing order (following page)

MEDICATION-SPECIFIC CLINICAL DOCUMENTATION

- Note should include any therapies tried/failed, and must include discussion about Skyrizi
- Medication list and allergies
- Baseline negative TB screening
- Baseline liver enzymes and bilirubin levels

GBIC INTERNAL USE

REFERRAL RECEIVED | BENEFITS VERIFIED | PA STATUS / THROUGH | SCHEDULED

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Prescribing Order - Skyrizi (risankizumab-rzaa) IV Induction

☐ New Start ☐ Maintenance DATE OF LAST DOSE / INFUSION

ORDER DETAILS

DATE OF ORDER | PATIENT NAME | DOB | M/F

DIAGNOSIS / ICD-10 | ☐ NKDA | PATIENT WEIGHT

ALLERGIES

PREMEDICATIONS

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Other

SKYRIZI MEDICATION ORDER - INDUCTION DOSING

☐ Skyrizi 600mg IV over 1 hour (Crohn's disease)

Dosing: ❑ Skyrizi 1200mg IV over 2 hours (ulcerative colitis)

Frequency: ❑ Week 0, Week 4, and Week 8

ADMINISTRATION & MONITORING

✓ Administer Skyrizi IV in 250ml 5% Dextrose or 0.9% Sodium Chloride over 1-2 hours per indication
✓ Do not administer if patient has active signs or symptoms of infection or hepatic dysfunction.
✓ In case of reaction, follow GBIC infusion reaction protocol. Notify physician.
✓ Signature Date

PROVIDER AUTHORIZATION

ORDERING PROVIDER NAME | NPI | DATE

SIGNATURE | OFFICE PHONE / EXT.

Handwritten or compliant electronic signature