

Skyrizi (Risankizumab-rzaa)

Provider Order Form rev. 7/20/2022



www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:		Patient Email:		
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

K50.90 Crohn's disease
Other: _____

MEDICATION ORDER

Skyrizi (Risankizumab-rzaa)

Dose:
600mg IV

Note: Administration will use the 600mg/10ml SDV

Frequency:
Week 0, week 4 and week 8

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg / PO IV
methylprednisolone (Solu-Medrol) 40mgIV 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order