McLeod Health

Risankizumab (Skyrizi) Treatment Plan for Gastroenterology

Patient Name: _____ DOB: _____

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

Patient Primary Phone Number: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

☐ K50.0___ Crohn's Disease (small intestine)

☐ K50.1___ Crohn's Disease (large intestine)

☐ K50.8___ Crohn's Disease (small and large intestine)

☐ K51.0___ Ulcerative (Chronic) Pancolitis

☐ K51.2___ Ulcerative (Chronic) Proctitis

☐ K51.3___ Ulcerative (Chronic) Rectosigmoiditis

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 Route: IVP

☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB

☐ Other (include drug, dose, and route): _____

Drug Orders:

☐ Rizankizumab (Skyrizi) (J2327) per 250 mL Sodium Chloride 0.9% IV to infuse IV over 1-2 hours

Dose: ☐ Crohn's Disease: 600 mg over 1 hour

☐ Ulcerative Colitis: 1200 mg over 2 hours

Frequency: ☐ Weeks 0, 4, and 8

☐ Other: _____

● Subcutaneous maintenance dosing to be initiated by physician office starting at Week 12 every 8 weeks thereafter

Lab Orders:

☐ _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received risankizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.