

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) ☐ K50.8___ Crohn's Disease (small and large intestine)
- ☐ K50.1___ Crohn's Disease (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

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.
- Appropriate access and line care orders per health system policy

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Lab Orders:



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.