EMORY HEALTHCARE

PHYSICIAN'S ORDERS

Therapy: Risankizumab Induction (Week 0, 4, 8)

[Place patient sticker here]

Name: ______
MRN: ______
DOB: ______

Today's Date ______ Time ______

Diagnosis: ______ Other: ______

Age: ______ Height (cm): ______ Weight (kg): ______ BSA (m^2): ______

ALLERGIES/Sensitivities: ☐ NKDA or ☐ ______

Start Date (at least 1 wk from today): ______ ☐ **Urgent (Call Infusion Center)**

Treatment Department: ☒ EHW OP Infusion

Appointment Requests: *Tolerance:* ☒ *Use default, for chronic treatments order valid for 1 year*

☐ Infusion Appointment Request – 2 hrs (for Crohn's Disease) Every 28 days x 3 occurrences
☐ Infusion Appointment Request – 3 hrs (for Ulcerative Colitis) Every 28 days x 3 occurrences

Treatment Conditions (Administer Treatment if): ☐ Once on Day 1

Initial Week 0

☐ AST/ALT LESS THAN 3 x ULN (within previous 3 months)
☐ Hepatitis B surface antigen and core antibody NONREACTIVE (within 365 days)
☐ Total Bilirubin LESS THAN 2 x ULN (within previous 3 months)
☐ Tuberculosis Test Negative (within previous 6 months)
☐ Okay to proceed with treatment before week 8 labs are resulted. **Week 8 labs should not delay treatment**
☐ Okay to treat. Include details here: ______

Labs: *Lab (if selected) will be done as per appointment frequency selected above (unless specified)*

☐ CMP ☐ Once
☐ CBC with diff ☐ Once
☐ C-reactive protein ☐ Once

Supportive Care: Every 28 days x 3 occurrences

☒ Sodium chloride prime bag 250 ml Once as needed, Prime Bag

Medications (SELECT ONE)

☐ Crohn's Disease: Risankizumab-rzaa (Skyrizi®) Every 28 days x 3 occurrences
600 mg in D5W 260 mL IVPB, administer over 60 min, starting 60 min after treatment start time

☐ Ulcerative Colitis: Risankizumab-rzaa (Skyrizi®) Every 28 days x 3 occurrences
1200 mg in D5W 270 mL IVPB, administer over 120 min, starting 60 min after treatment start time

Emergency Medications ☒ *Order will be done as per appointment frequency*

☒ Hypersensitivity reaction protocol
Protocol Document: https://emory.ellucid.com/documents/view/15307/15641

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	