Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP risankizumab (Skyrizi) (Paper)

Diagnosis: ☐ Moderate to Severe Ulcerative Colitis **ICD10:** _____
☐ Moderate to Severe Crohn's

Verification of T SPOT/PPD or Quantiferon: TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: _____/_____/_____ Result: _____
Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____
PPD: Date: _____/_____/_____ Result: _____

Baseline Labs:
Bilirubin Total (0.0 – 1.0): Date: _____/_____/_____ Result: _____
Alkaline Phosphatase (35 – 104): Date: _____/_____/_____ Result: _____
Alanine Aminotransferase [ALT] (0 – 33): Date: _____/_____/_____ Result: _____
Aspartate Aminotransferase [AST] (0 – 32): Date: _____/_____/_____ Result: _____

IV Access:

☐ Saline Lock:
☑ *Insert peripheral Saline Lock; may leave in for consecutive treatment days*
☑ *Discontinue Saline Lock after therapy completed*

☐ PICC Line:
☑ *Routine PICC Line Care, labs and restoration*
☐ *Discontinue PICC Line (verify regimen is complete with provider prior to removing line)*

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
☑ *Porta cath access, labs, restoration and de-access / Central Access Device use and care*

Height: _____ *cm* **Weight:** _____ *kg*

Laboratory:

☑ **+8 Weeks** Bilirubin Total *BLOOD, Routine, Repeat baseline labs while in clinic for dose #3 (8 week dose)*
☑ **+8 Weeks** Alkaline Phosphatase *BLOOD, Routine, Repeat baseline labs while in clinic for dose #3 (8 week dose)*
☑ **+8 Weeks** Alanine Aminotransferase *BLOOD, Routine, Repeat baseline labs while in clinic for dose #3 (8 week dose)*
☑ **+8 Weeks** Aspartate Aminotransferase *BLOOD, Routine, Repeat baseline labs while in clinic for dose #3 (8 week dose)*

Medication:

☐ Provider Communication *Wait for lab results before infusing risankizumab (Skyrizi)*

Initial Treatment for Crohn's

☐ *risankizumab (Skyrizi),* ***600 mg*** *= 10 mL, Soln, IVPB, ONCE, Infuse Over: 2 hr, Comments: Mix in 250 mL D5W*

Initial Treatment Frequency: ☐ *One time dose* ☐ *Weeks 0, 4, and 8*

Initial Treatment for Ulcerative Colitis

☐ *risankizumab (Skyrizi),* ***1200 mg*** *= 20 mL, Soln, IVPB, ONCE, Infuse Over: 2 hr, Comments: Mix in 250 mL D5W*

Initial Treatment Frequency: ☐ *One time dose* ☐ *Weeks 0, 4, and 8*

Maintenance Treatment

risankizumab (Skyrizi) subcutaneous solution *****TO BE SENT AS A PRESCRIPTION TO PATIENT'S PREFERRED PHARMACY BY PROVIDER***

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Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS