Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ________________________________ Patient D.O.B.___________________________

Current Height: ____________________________ Current Weight___________________________

Patient Phone # (______) _______-________________ Gender________________________

Patient Address ____

City_________________ State _______________ Zip Code__________________________

Related Diagnosis Code (ICD-10 code): ____

Referring Provider (Please Print) ____

Office Phone # (______) _______-________________ Office Contact: ____________________________

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Skyrizi (Risankizumab-rzaa) Treatment Plan

Patient Name: ______________________________ **Patient DOB** ______________________________

General

☐ Diagnosis- ______________________________ ICD-10 Code _______________

Pt. Weight _____________ Pt Height _____________ Known Allergies _____________

Requested Start Date ____/____/_______

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_______

Authorized Treatment Duration ☐ 12 Months ☐ Other _____________

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)

every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

Pre- Treatment Medications

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before dose

Skyrizi (risankizumab-rzaa)

☐ *600 mg, IV Piggyback, Soln-IV (Week 0,4,8)*
Comments: in 250ml NS infused IV over 60 minutes. Do not administer diluted solution concomitantly in the same IV line with other medicinal products.

☐ *1200 mg, IV Piggyback, Soln-IV (Week 0,4,8)*
Comments: in 250ml NS infused IV over 120 minutes. Do not administer diluted solution

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature ________________________ Provider Name (please print)________________________

Date_____/_____/__________

Skyrizi (Risankizumab-rzaa) Treatment Plan

concomitantly in the same IV line with other medicinal products.

☑ Communication Order (Month 1 to 12)
Provide FDA medication guide to patient

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative HCG urine screening completed prior to each infusion for females 11-55 years of age with no history of hysterectomy or bilaterial oophorectomy

☑ Communication Order (Month 1 to 12)
Ensure the following lab results (hepatic function panel) are available within the last 30 days before first dose and prior to week 8 treatment. If results not available, draw labs and reschedule infusion.

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
for positive HCG urine screen prior to infusion initiation.

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
For abnormal results of hepatic function panel. Hold infusion for provider clearance prior for any abnormal results.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ HCG Pregnancy Screening- Urine (If Needed)

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)

☑ CMP (If Needed)

☑ CBC w/ Diff (If Needed)

<u>Provider Acknowledgement</u>

** Referring provider acknowledges that ongoing patient monitoring for cirrhosis and liver enzyme elevation is needed. Should abnormalities be identified CMC infusion services will promptly notify referring provider who will assume responsibility for cause investigation. Referring provider to coordinate with patient / insurer for maintenance dose of subcutaneous On- Body Injector (OBI).

Provider Initials________________

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _______________________ Provider Name (please print)_______________________

Date____/____/_________ Patient Name __________________________ Patient DOB______________