DURANGO INFUSION

INFUSION SUITE		SKYRIZI INFUSION ORDERS	
Durango Infusion Center		**Phone: 970-828-3500**	**Fax: 970-828-3501**
270 E 8th Ave Ste N101 Durango, CO 81301			
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		**DOB:**	
MEDICAL INFORMATION			
ICD10:		**Patient Height:**	
Patient Weight (kg):		**Allergies:**	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
☐ **TB: _____ LFT's:_____**			
Additional labs:			
☐ **Insert IV**	☐ **Access Port/PICC**		
PREMEDICATIONS 30 minutes prior to starting			
☐ **Acetaminophen:**	☐ 325mg PO X1	☐ 500mg PO X1	☐ 650mg PO X1 ☐ 1000mg PO X1
☐ **Diphenhydramine:**	☐ 25mg IV X1	☐ 25mg PO X1	☐ 50mg IV X1 ☐ 50mg PO X1
☐ **Solumedrol:**	☐ 40mg IV X1	☐ 100mg IV X1	☐ 125mg IV X1
☐ **Antihistamine:**	☐ Cetirizine 10mg PO X1	☐ Loratadine 10mg PO X1	
☐ **Additional PRN:**			
SKYRIZI ORDERS		***Crohn's Diagnosis Only**	
☐ Skyrizi:	600mg IV over 1 hour in _____mL week 0, Week 4, and Week 8		
POST INFUSION			
☐ Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
☐ Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
☐ Discharge home			
Referring Provider Printed:			
Referring Provider Signature:		**Date:**	
Referring Provider Phone:		**Referring Provider Fax:**	
DNG Provider Printed:			
DNG Provider Signature:		**Date:**	

Credentials must be included

Infusion Directions:

- Withdraw 10 mL of Skyrizi solution from the vial and inject into an intravenous infusion bag or glass bottle**:**
  5% Dextrose (600 mg/10 mL in 100 mL, or 250 mL, or 500 mL)
  Final concentration of approximately 1.2mg/mL to 6 mg/mL.
- Do not shake the vial or diluted solution in the infusion bag or glass bottle
- Allow the diluted Skyrizi to come to room temperature prior to administration
- Infuse over at least 1 hour. Infusion must be completed within 8 hours of dilution.