

INFUSION SUITE		SKYRIZI INFUSION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500 Fax: 970-828-3501	
PATIENT INFORMATION - If Outside Referral, Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10 / Diagnosis:		Height:	
Allergies / Hypersensitivities:		Weight (kg):	
		*Weigh patient at each visit	
REQUIRED CLINICAL DOCUMENTATION			
<input type="checkbox"/> TB *Initiation		<input type="checkbox"/> ALT, AST, Bilirubin Prior to initiation and then every 4 weeks	
Additional labs:			
<input type="checkbox"/> Insert IV		<input type="checkbox"/> Access Port/PICC	
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Cetirizine 10mg PO X1		<input type="checkbox"/> Loratadine 10mg PO X1
<input type="checkbox"/> Additional PRN:			
SKYRIZI ORDERS			
<input type="checkbox"/> Skyrizi 600 mg IV in _____ mL NS over 1 hour on week 0, week 4, and week 8 for Crohn's and Plaque Psoriasis			
<input type="checkbox"/> Skyrizi 1200 mg IV in _____ mL NS over 2 hours on week 0, week 4, and week 8 for Ulcerative Colitis			
POST INFUSION			
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.			
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess			
<input type="checkbox"/> Discharge home			
Referring Provider Printed:			
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

Vaccinations: No live vaccines 30 days prior to infusing or during Skyrizi treatment

Infusion Directions:

- Withdraw Skyrizi solution from the vial(s) and inject into an intravenous infusion bag or glass bottle:
Crohn's / Plaque Psoriasis - 600mg dose in 100 mL, 250 mL, or 500 mL NS
Ulcerative Colitis - 1200 mg dose in 250 mL or 500 mL NS
- 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 for **600mg dose** and 2 hours for **1200mg dose**