Skyrizi Order
(risankizumab-rzaa)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ❒ Demographics ❒ Insurance Information ❒ Current Medications ❒ H & P Relevant to Diagnosis ❒ Medications List ❒ TB Labs

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS: *(USUALLY NOT INDICATED)*

❒ Diphenhydramine	25mg	❒ PO	❒ IV	❒ Pre-med	❒ PRN
❒ Acetaminophen	650mg		PO	❒ Pre-med	❒ PRN

❒ Other OTC _____

SKYRIZI (RISANKIZUMAB-RZAA) IV DOSAGE

For Crohn's Disease

600mg/250mL 5% dextrose, Infuse over 1 hour

Induction Dose at 0, 4, and 8 weeks

Start Date of Infusion: _____