Holland Hospital
AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
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Skyrizi (risankizumab) Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply.)

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

TB Test Result: _____ **Date:** _____ **Initial TB Test required prior to first dose. Any subsequent testing optional and to be ordered and evaluated by provider.*

- Obtain liver enzymes and bilirubin levels prior to initiating treatment with SKYRIZI.
- Provider is responsible for verifying liver enzymes & bilirubin levels are within normal limits prior to initiating orders.

MEDICATION

Skyrizi IV (Risankizumab)

☐ 600mg IV *(For treatment of Crohn's disease)* Initial dose at 0, 4 and 8 weeks.
- Infuse over 1 hour

☐ 1200mg IV *(For treatment of Ulcerative Colitis)* Initial dose at 0, 4 and 8 weeks.
- Infuse over 2 hours

- Vital signs to be completed prior to infusion, 30 min after start of infusion and at the completion of infusion.
- Monitor for signs of hypersensitivity reaction.
- Check for active infection. If there is an active infection, dose should be held. Contact provider for guidance whether to continue treatment.

Treatment for adverse drug reactions: (*for mild to moderate infusion reaction*)

- Slow or stop infusion for 20 minutes.
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". *(Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)*
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____