KAISER PERMANENTE®

risankizumab-rzaa (SKYRIZI) – Crohn's Disease
Infusion Therapy Plan Orders

Page 1 of 3

Name: _____

Kaiser Permanente Member I.D. #: _____

Date of Birth: _____

Instructions to Provider
Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol).
Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all the following:

□ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice:** 1-800-289-1363

Order Date: _____

Weight: _____kg

Diagnosis
ICD-10 code (*REQUIRED):* _____

ICD-10 description: _____

General Plan Communication

- **Induction [Crohn's Disease]:** Infuse risankizumab 600 mg loading dose at Week 0, Week 4, and Week 8
- **Maintenance:** Inject risankizumab 180 mg or 360 mg subcutaneously every 8 weeks starting 4 weeks after third risankizumab infusion. Use lowest effective dose needed to maintain therapeutic response
- **A separate prescription or order is needed for subcutaneous maintenance doses**
- **Special instructions/notes:**

  _____

Provider Information

- Ensure baseline PPD or quantiFERON-TB assay are negative for latent TB
- Suggested induction monitoring: LFTs at baseline and within 1 week of the 3rd induction (week 8) infusion
- Treatment with risankizumab not recommended in patients with active, severe infections. Consider withholding risankizumab in patients who develop a severe infection while on treatment
- Ensure an immunization plan is in place before initiating therapy
- Live vaccines should not be given concurrently or within 1 month prior to initiation of therapy

Infusion Therapy

☑ **risankizumab (SKYRIZI) 600 mg in D5W** (250 mL)

Dose: □ 600 mg

Route: Intravenous

Frequency: Every 4 weeks for 3 infusions

Infusion Rate: Infuse over 60 minutes

If infusion-related reaction:

1) STOP infusion immediately
2) Begin primary infusion to wide open rate
3) Notify MD
4) Monitor vital signs
5) Administer PRN medications
6) 30 minutes after symptoms have resolved, restart infusion at 50% of rate when reaction occurred

Note any changes to above regimen:

_____

Pre-Medications

☑ **acetaminophen (TYLENOL) tablet**

Dose: 650 mg ***Route:*** Oral ***Frequency:*** Once, 30 minutes prior to risankizumab infusion if patient has history of prior reaction. May also be given once as needed during infusion for achiness, headache, or fever

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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☑	**cetirizine (ZYRTEC) tablet**		
	Dose: 10 mg	***Route:*** Oral	***Frequency:*** Once, 60 minutes prior to risankizumab infusion (if not taken at home) if patient has history of prior reaction
☑	**Other: _____**		
	Dose: _____	***Route:*** Oral	***Frequency:*** Once, 30 minutes prior to risankizumab infusion
IV Line Care			
☑	**5% Dextrose (D5W) infusion 250 mL**		
	Rate: 30 mL/hr	***Route:*** Intravenous	***Frequency:*** Run continuously to keep vein open. Start peripheral IV if no central line
PRN & Hypersensitivity Reaction Medications			
☑	**acetaminophen (TYLENOL) tablet**		
	Dose: 650 mg	***Route:*** Oral	***Frequency:*** Take 650 mg PO every 4 hours PRN for fever (greater than 100.4 F), myalgias, arthralgias or headache.
☑	**alteplase (CATHFLO ACTIVASE) injection**		
	Dose: 2 mg	***Route:*** Intracatheter	***Frequency:*** Instill 2 mg to affected port(s) of central venous catheter if sluggish or occluded. Allow to dwell for 30 minutes, if unable to aspirate blood allow to dwell for an additional 90 minutes. May repeat one time if unsuccessful.
☑	**diphenhydrAMINE (BENADRYL) injectable**		
	Dose: 20 mg	***Route:*** Intravenous	***Frequency:*** Give IV push over 2 minutes for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Give immediately after diphenhydrAMINE. Notify provider if patient experiences a hypersensitivity reaction.
☑	**famotidine (PEPCID) (PF) injection**		
	Dose: 20 mg	***Route:*** Intravenous	***Frequency:*** Give IV push over 2 minutes for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Give immediately after diphenhydrAMINE. Notify provider if patient experiences a hypersensitivity reaction.
☑	**methylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF)**		
	Dose: 125 mg	***Route:*** Intravenous	***Frequency:*** Give 125 mg IV push one time PRN for shortness of breath, bronchospasm, or other symptoms of a suspected hypersensitivity reaction not otherwise specified. Notify provider if patient experiences a hypersensitivity reaction. reaction.
☑	**sodium Chloride 0.9% IV bolus**		
	Dose: 1000 mL	***Route:*** Intravenous	***Frequency:*** Give IV over 1 hour one time PRN for hypotension due to presumed anaphylaxis. Notify provider if patient experiences a hypersensitivity
☑	**EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector**		
	Dose: 0.3 mg	***Route:*** Intramuscular	***Frequency:*** Once PRN for anaphylaxis. Give IM one time for severe cardiovascular or respiratory sumptoms (e.g. dyspnea, wheeze/bronchospasm, stridor, hypoxemia) of a suspected hypersensitivity reaction. Provider must be present upon given medication.

Nursing Orders

- Verify that patient meets the lab parameters for administration:
  - PPD or quantiFERON-TB assay for latent TB results are negative for TB.
  - HBV sAg and cAb labs have been completed by the ordering provider.
  - LFTs have been drawn at baseline and within 1 week of the 3rd induction (week 8) infusion

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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- Do not infuse risankizumab without negative TB, HBV sAg, and HBV cAb results. Notify provider if positive result.
- Begin D5W as primary line to keep vein open.
- Perform assessment for toxicity and tolerance.
- Monitor for temperature greater than 100.4F, chills, pruritus, chest pain, blood pressure changes (notify MD if greater than 10% drop in systolic blood pressure or if patient is symptomatic), or dyspnea.
- For hypersensitivity: stop risankizumab, give diphenhydramine and steroid as ordered.
- Review discharge medications, instructions, and future appointments.

References

risankizumab-rzaa® (SKYRIZI) injection for subcutaneous or intravenous use Prescribing Information. Revised June 2024.

Kaiser Permanente Infusion Locations

Please refer to the link below for the current list:
https://wa-provider.kaiserpermanente.org/patient-services/ambulatory-infusion

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____