NEW ENGLAND
Cancer Specialists

Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Skyrizi (risankizumab-rzaa)

Patient Name:_____ DOB:_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Required labs: CBC with differential and CMP at baseline, CMP prior to week 8 dose, TB and HBV screening prior to starting therapy

Crohn Disease : IV Induction dosing/frequency:

☐ **600 mg IV at week 0, 4, and 8**

Ulcerative colitis : IV Induction dosing/frequency:

☐ **1200 mg IV at week 0, 4, and 8**

*** In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____
Provider Signature: _____ Date: _____
Phone: _____ Fax: _____ Pager: _____