Skyrizi
INFUSION order

Patient Name

DOB

Phone

M F

DIAGNOSIS *Please provide ICD-10 code*

K50.00 Chron's disease of small intestine without complications

K50.90 Chron's disease, unspecified

K50.918 Chron's disease, unspecified, with other complication

K51.90 Ulcerative Colitis, unspecified

PRE-MEDICATION

(other)

Skyrizi ORDERS

DOSAGE

600mg intravenous infusion on week 0, 4, 8

1200mg IV on week 0, 4, 8

180mg SC on week 12 then every __ weeks thereafter or

360mg SC on week 12 then every __ weeks thereafter

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Signature **X**

Date

Provider

Phone

Fax

v1. 7 Copyright 201 9, Intellectual Property of WeInfuse , LLC