



Edward-Elmhurst Cancer Centers

120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Skyrizi (Risankizumab-rzaa) Standing Order

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable.*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call

Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

Contact Name and Phone

Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Allergies: _____

Diagnosis (ICD 10 Required): _____

Pre-administration labs:

- CBC with differential Date: _____
- Complete Metabolic Panel Date: _____
(with Bilirubin and Hepatic Function Panel)
- Quantiferon TB Gold Date: _____
- Hepatitis B Surface Antigen Date: _____

Labs:

Please draw the following labs (please check):

- Hepatic Function Panel
- Other: _____

Desired Frequency (please check):

- Each Infusion
- Other: _____

Dose/Administration:

Dose: _____ every 4 weeks x 3 doses

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient, and your office will receive notification of the event.

If your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Patients may be discharged post-infusion if stable. No monitoring time required.

Physician Signature: _____ Date: _____

Ordering Physician NPI: _____ Swedish Hospital NPI: 1831151257

Physician Name (Please Print) Office Phone Fax Number

Revision/Review Date: 4/18/25