

ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinical notes
- Insurance card, front and back

Tildrakizumab-asmn (Ilumya)

Provider Order Form



Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:
NURSING		
<input checked="" type="checkbox"/> Provide nursing care per IVX Standard Nursing Procedures, including reaction management		
<input checked="" type="checkbox"/> Referring office to provide TB status and date (please provide a copy of results) _____		
INJECTION THERAPY		
<input checked="" type="checkbox"/> Tildrakizumab-asmn (Ilumya)		
▪ Dose: <input type="checkbox"/> 100mg		
▪ Route: subcutaneous injection		
▪ Frequency: <input type="checkbox"/> weeks 0, 4 then every 12 weeks thereafter / <input type="checkbox"/> every 12 weeks		
<input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion		
<input type="checkbox"/> Patient is NOT required to stay for observation time		
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)		
GENERAL PLAN COMMUNICATION		
Special instructions/notes:		

Ordering Provider: Initial here _____ and proceed to the next page.

REACTION MANAGEMENT

- Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- If reaction occurs:
 - Stop infusion
 - Maintain/establish vascular access
 - Notify referring provider
 - Consider giving the following PRN
 1. Acetaminophen (Tylenol) 650mg PO **OR** _____mg for pain or fever > 38 C/100.4 F
 2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
 3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
 4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting
 5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push
 6. Other _____
 - When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines
- Severe allergic/anaphylactic reaction:**
 - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
 1. Call 911
 2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
 3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
 4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
 5. Have Automated External Defibrillator available
 6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
 7. Discontinue treatment

Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with ILUMYA. Initiate treatment of latent TB prior to administering ILUMYA

Patient Name

Patient Date of Birth

Provider Name (Print)

Provider Signature

Date

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ____ San Mateo ____ Fremont ____ San Ramon ____ TBD

ILLINOIS fax: (312) 253-7244 | ____ Glenview ____ Schaumburg ____ TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ____ Overland Park, KS ____ Lee's Summit, MO ____ Briarcliff, MO ____ TBD

OHIO fax: (844) 627-2675 | ____ Dublin ____ Pickerington ____ TBD

PENNSYLVANIA fax: (844) 820-9641 | ____ Malvern ____ Bensalem ____ Montgomeryville ____ East Shore ____ West Shore ____ TBD

TENNESSEE fax: (844) 627-2518 | ____ Brentwood ____ Hendersonville ____ TBD

