

Tildrakizumab-asmn (Ilumya®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____kg Height: ____cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____	
Diagnosis <input type="checkbox"/> Psoriasis Vulgaris (L40.0) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____		Labs No labs required. Labs to be ordered by physician. <input type="checkbox"/> Other: _____	
Date of negative Tuberculosis Screen: _____			
Tildrakizumab-asmn (Ilumya) subcutaneous injection Dose: <input type="checkbox"/> 100 mg <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> Week 0 and 4, then every 12 weeks <input type="checkbox"/> Every 12 weeks <input type="checkbox"/> Other: _____			
Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____		Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other: _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care		<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care

<p>Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary</p>	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure
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Provider Name: _____	Provider Signature: _____
Attending Physician Name: _____	Provider NPI: _____
Office Phone Number: _____	Office Fax Number: _____
<p><i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i></p>	