Fax your completed order to 877-734-1157

Patient Name: ________________________DOB: ____/___/________Date of Last Infusion: ______/___/_________
Height___________Weight__________
Infusion Location: (state and site) ____________________________________

Ilumya® (tildrakizumab-asmn) Orders

Diagnosis (please provide ICD-10 code in space provided):

________Plaque Psoriasis ________Other: ____________________________

Patient Weight: ______________________ TB Result/Date: _______________________________________

Nursing Orders:
-Hold and notify provider if patient reports current infection
-Hold and notify provider if patient reports recent live vaccine
-Hold and notify provider of pregnant or breast feeding

Administer Ilumya® 100mg/1mL subcutaneously in the upper arm, abdomen or upper thigh

Frequency:

- ❑ Week 0, Week 4, Every 12 Weeks
- ❑ Every 12 Weeks
- ❑ Other: _________________________

Observation Period:

- Monitor patient for post injection observation period of 15 mins after first injection. If no reaction occurs, no further observation period is required
- Record Vital signs prior to discharge
- If a patient develops bronchospasm, angioedema, hypotension, urticaria, or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol to include administration of epinephrine 0.3 mg IM STAT

Additional Orders:

Provider Name (print)_____________________________________Date:____________________________

Provider Signature:____Time: _____________________________