Tildrakizumab-asmn (Ilumya)

Provider Order Form *rev. 10/12/2022*

14107 Cortez Blvd
Brooksville FL 34613
P: (352)549-9962
F: (352)549-9963
www.360infusioncenter.com
E: info@360infusioncenter.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (list results here & attach clinicals)

_____

☑ Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **Tildrakizumab-asmn** (Ilumya)

- Dose: ☐ 100mg
- Route: subcutaneous injection
- Frequency: ☐ weeks 0, 4, and then every 12 weeks thereafter / ☐ every 12 weeks

☐ Patient is required to stay for 30-minute observation

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

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

Provider Name (Print) **Provider Signature** **Date**