Fax: 614-929-7199 | Phone: 614-929-3349| Email: info@infuseoneohio.com

(Tildrakizumab-asmn)

Ilumya injection orders

INFUSE ONE

Patient Name ________________________________ DOB _____________

Phone Number ____________________________ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _______________ Moderate to Severe Plaque Psoriasis ☐ ______________ Other

PRE-MEDICATIONS

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ ______________________ (other)

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____________________ (other)

Ilumya (Tildrakizumab-asmn) ORDERS

DOSAGE & FREQUENCY

☐ 100mg SQ at weeks 0, 4, and then every 8 weeks thereafter

- Please fax the patient's TB test results with this completed form

Patient Weight
________ **lbs**
________ **kg**

NOTES:

ORDERING PROVIDER

Signature __________________________________ Phone__________________Fax__________________

Provider ____ Date _________________