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

(Ixekizumab)

Taltz infusion orders

Patient Name ____ DOB ________________

Phone Number ___________________________________ M ____ F _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _________________ Psoriatic Arthritis

☐ ________________ Plaque Psoriasis

☐ _________________ Ankylosing Spondylitis

PRE-MEDICATIONS

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

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

Taltz (Ixekizumab) ORDERS

DOSAGE & FREQUENCY

☐ 160mg once, followed by 80 mg every 4 weeks
☐ 160mg once, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12, & then 80mg every 4 weeks

Patient Weight
_________ **lbs**
_________ **kg**

NOTES:

ORDERING PROVIDER

Signature _______________________________________ Phone____________________Fax____________________

Provider ____ Date ___________________