



Thank you for selecting our infusion services team to care for your patient. If you are not a PeaceHealth provider, all information listed below is required before we can process orders and schedule your patient for treatment.

**Part A- Patient scheduling and contact information:**

Patient Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Contact Information and Phone Number(s): \_\_\_\_\_

Ordering Provider Name (Print): \_\_\_\_\_

Provider Clinic or Service Address: \_\_\_\_\_

Clinic or Service Phone Number: \_\_\_\_\_ Clinic or Service Fax Number: \_\_\_\_\_

Diagnosis (include ICD 10 codes): \_\_\_\_\_

Medication and Service Requested- list J-Code/CPT code if known: \_\_\_\_\_

**Date Service is Requested to Begin:** \_\_\_\_\_ **Date Service is Expected to End:** \_\_\_\_\_

*Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.*

**Part B- Insurance and Prior Authorization.** Any non-PeaceHealth provider must obtain prior authorization prior to service. Attach a copy of authorization documentation received from insurance payer when submitting orders.

Insurance (Payer) Company: \_\_\_\_\_

Prior Authorization Number and Conditions: \_\_\_\_\_

Prior Authorization Expiration Date: \_\_\_\_\_

Insurance (Payer) Contact Phone Number: \_\_\_\_\_

**Part C- Elements needed to guide medication therapy are included with request for service:**

- All orders and instruction (please use the PeaceHealth approved ordering form) are complete and include provider signature AND printed name at the bottom of each order page. Check the boxes of ALL orders you would like to activate.
- For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

**If information is located outside of PeaceHealth's electronic medical record system attach the following:**

- A list of current medications reconciled by patient provider is available and includes a list of known allergies.
- Recent progress notes from ordering provider.
- A copy of relevant laboratory results and other appropriate supporting documentation.

**IMPORTANT MESSAGE TO PROVIDERS:** To reduce delays in treatment and phone calls to your office you may participate in the PHMC formulary process by signing this document. A clinical pharmacist will adjust orders according to PHMC approved policies and procedures.

*I agree to utilize PHMC policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PHMC. This agreement will be issued for the duration of active orders contained within this treatment plan.*

**PROVIDER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**FAX completed service request and completed orders to: PHMC OP Infusion and Nursing Services 541-902-1649**



## Tildrakizumab-asmn (Ilumya) Outpatient Infusion Therapy Plan

**All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.**

Heading	Content
<b>For Admission to Service</b>	<p><b>Provider Instruction</b> – Review information below and address requirements for admission to service.</p> <ol style="list-style-type: none"> <li>1. Provider has verified that patient is up to date with all immunizations prior to initiation. Live vaccines should not be given concurrently.</li> <li>2. Provider has screened patient for tuberculosis, acute or chronic infections, hepatitis B, and HIV prior to injection. <b>Date of negative screening:</b> _____ (required for service)</li> <li>3. Provide patient with the FDA approved medication guide for tildrakizumab (Ilumya).</li> </ol>
<b>Supportive Care</b>	<p><input checked="" type="checkbox"/> <b>Tildrakizumab-asmn (Ilumya)</b> 100 mg subcutaneous injection:</p> <p><b>Select Frequency:</b></p> <p><input type="checkbox"/> Initiation regimen administered at 0 and 4 weeks <i>followed by</i> maintenance regimen every 12 weeks</p> <p><input type="checkbox"/> Maintenance regimen every 12 weeks</p>
<b>Labs</b>	<p><input type="checkbox"/> CBC with differential once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> CMP once prior to beginning treatment and every _____ weeks</p> <p><input type="checkbox"/> Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.</p>
<b>Nursing Orders</b>	<p><input checked="" type="checkbox"/> Prior to administration, remove prefilled syringe from the refrigerator and allow to warm at room temperature for 30 minutes in original carton. Do not warm any other way. Rotate injection site to thighs, upper arm or abdomen (2 inches away from navel).</p> <p><input checked="" type="checkbox"/> Monitor for signs and symptoms of infection. Hold tildrakizumab and notify provider for signs and symptoms of infection.</p> <p><input checked="" type="checkbox"/> Assess vital signs prior to injection and after injection.</p> <p><input checked="" type="checkbox"/> Patient may be discharged 15 minutes post-injection if there is no evidence of adverse reaction and vital signs are stable.</p>
<b>Emergency Medications</b>	<p><b>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</b></p> <p><input checked="" type="checkbox"/> <b>Standard Emergency Medications:</b></p> <p><input checked="" type="checkbox"/> <b>DiphenhydrAMINE (Benadryl)</b> injection 25-50 mg IM once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (&gt;/= 20 points in SBP), nausea, urticaria, chills, pruritis).</p> <ul style="list-style-type: none"> <li>• Administer 50 mg IM if patient has NOT had diphenhydramine within 2 hours of reaction.</li> <li>• Administer 25 mg IM if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IM dose for a total of 50 mg and notify provider.</li> </ul> <p><input checked="" type="checkbox"/> <b>Albuterol</b> 90 mcg/actuation inhaler 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available.</p> <p><input checked="" type="checkbox"/> <b>MethylPREDNISolone (Solu-Medrol)</b> injection 125 mg IM once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (&gt;/= 20 points in SBP), nausea, urticaria, chills, pruritis) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl) and notify provider. Do not inject into deltoid.</p>

**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

*Final page of orders must include signature of the ordering practitioner, date, and time.*

Patient Identification Label



**Tildrakizumab-asmn (Ilumya)  
Outpatient Infusion Therapy Plan**

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
	<input checked="" type="checkbox"/> <b>EPINEPHrine (Adrenalin)</b> injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (>/= 40 points in SBP), shortness of breath with wheezing and O2 Sat < 90%) and notify provider.
Referral	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	<b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b> <b>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department</b> 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX <b>541-902-1649</b>
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ <input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy

**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

*Final page of orders must include signature of the ordering practitioner, date, and time.*