

ILUMYA INJECTION REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:		
DATE OF REFERRAL:	ADDRESS:		
DATE OF BIRTH:	CITY, STATE, ZIP:		
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:			
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE		MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST		NKDA

PRIMARY DIAGNOSIS:

ICD-10 CODE: L40.0 - Psoriasis Vulgaris	L40.9 - Psoriasis, unspecified (do not use for Medicare patients)	Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

1. INSURANCE CARD (Front & Back)
 2. PATIENT DEMOGRAPHICS
 3. MOST RECENT LABS
 4. MEDICATION LIST
 5. H & P
 6. NEGATIVE TB TEST RESULTS
 7. DOCUMENTATION OF ALL PREVIOUSLY ATTEMPTED THERAPIES

PRIMARY MEDICATION ORDER:

PRN & PREMEDICATIONS:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy. Ilumya (tildrakizumab-asmn) 100mg subcutaneous injection administered at week 0, week 4, and every 12 weeks thereafter. Other: FIRST DOSE: Y N <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.	MEDICATIONS	30 minutes prior to every injection	PRN
	Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate injection reaction.
	Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate injection reaction.
	Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate injection reaction.
	Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate injection reaction.
	Other: _____		PRN every ___ hour for mild or moderate injection reaction.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
 START PIV/ACCESS CVC (As Needed for ADVERSE REACTIONS)
 OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

_____ → (GENERIC SUBSTITUTION PERMITTED)
 PHYSICIAN SIGNATURE: _____ DATE: _____

_____ → (DISPENSE AS WRITTEN)
 PHYSICIAN SIGNATURE: _____ DATE: _____

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INJECTION REACTION	MODERATE INJECTION REACTION	SEVERE INJECTION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.