Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Tildrakizumab (ILUMYA) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Tildrakizumab may increase the risk of infections; upper respiratory infusions have occurred more frequently. Consider the risks versus benefits prior to treatment initiation in patients with a history of chronic or recurrent infection. Treatment should not be initiated in patients with clinically important active infections until it is resolved or treated. Monitor for signs and symptoms of infection.
5. Patient should be brought up to date with all immunizations before initiating therapy. Live vaccines should not be given concurrently.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. 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 in any other way.
3. Monitor for signs and symptoms of infection. Advise patient to report symptoms of infection.

MEDICATIONS:

tildrakizumab-asmn (ILUMYA), 100 mg, subcutaneous, ONCE.
Rotate injection site to thighs, upper arm, or abdomen (2 inches away from navel). Allow prefilled syringe (in original carton with lid closed) to sit at room temperature for 30 minutes before injecting.

- ☐ **Induction and Maintenance:** Administer at weeks 0, 4, and then every 12 weeks thereafter.
- ☐ **Maintenance only:** Administer every 12 weeks starting now.

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**