Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Ilumya® (tildrakizumab-asmn) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Plaque Psoriasis (ICD-10)

_____ Other: _____ (ICD-10)

Patient Weight: _____ TB Result/Date: _____

Nursing Orders:

- ☑ Hold and notify provider if patient reports current infection.
- ☑ Hold and notify provider if patient reports recent live vaccine.
- ☑ Hold and notify provider if patient reports previous reaction to Ilumya®
- ☑ Hold and notify provider if patient reports pregnant or breast feeding

Administer **Ilumya® 100mg/1mL subcutaneously** in the upper arm, abdomen or upper thigh.

Frequency:

- ☑ Week 0, Week 4, Every 12 Weeks
- ☑ Every 12 Weeks
- ☑ Other: _____

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Created 4/6/2021. Order valid for one year unless otherwise indicated.