



INFUSION SUITE		ILUMYA INJECTION ORDERS	
406 Arthritis Clinic LLC 2409 Arnold Ln Ste 9 Billings, MT 59102		Phone: 406-345-0211	Fax: 747-205-0742
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
<input type="checkbox"/> TB: _____ *Annual			
Additional labs:			
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1 <input type="checkbox"/> 500mg PO X1 <input type="checkbox"/> 650mg PO X1		
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IVP X1 <input type="checkbox"/> 25mg PO X1 <input type="checkbox"/> 50mg IVP X1 <input type="checkbox"/> 50mg PO X1		
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1 <input type="checkbox"/> 100mg IV X1 <input type="checkbox"/> 125mg IV X1		
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:			
ILUMYA ORDERS			
<input type="checkbox"/> Loading:	Ilumya 100mg subcutaneous at week 0 and week 4		
<input type="checkbox"/> Maintenance:	Ilumya 100mg subcutaneous every 12 weeks X _____		
POST INJECTION			
<input type="checkbox"/> Discharge home			
Referring Provider Printed:			
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
406 Provider Printed:			
406 Provider Signature:		Date:	

**Credentials must be included*

Injection Directions:

- Remove pre-filled syringes and allow to sit at room temperature for at least 30 minutes
- Inject in the thigh, abdomen (greater than 2" around navel), or outer area of upper arm

Nursing Considerations:

- Air bubbles may be present in the prefilled syringe, there is no need to remove them.
- Syringe has a safety mechanism - when injecting, depress the blue plunger completely