

ILUMYA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other Phone: _____
Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here
Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ L40.0 (Psoriasis Vulgaris) ☐ L40.8 (Other psoriasis) ☐ Other: _____
Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in
TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT INFORMATION

ILUMYA ((tildrakizumab-asmn))

Route: Subcutaneously

Dose: 100mg prefilled syringe

Frequency:

- ☐ Loading: Once at week 0 and 4
☐ Maintenance: Once every 12 weeks

Quantity: _____ Refills: _____

Premedication Protocol:

- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Other: _____
Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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