RESTORE HEALTH
INFUSION AND WELLNESS

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: _____