



# Ilumya

Provider Order Form

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Patient Cell Phone: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency/Alternate Contact Name: \_\_\_\_\_ Emergency/Alternate Contact Phone: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight lbs/kg: \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy  Therapy Change Last infusion date (if applicable): \_\_\_\_\_

### REQUIRED DOCUMENTATION

Labs Insurance Card (front and back) Current Medications History/Progress Notes

### ICD-10 CODE

L40.0 Psoriasis vulgaris; Plaque psoriasis Other: \_\_\_\_\_

### PRE-MEDICATION ORDER

|                                |         |       |           |   |          |          |    |    |
|--------------------------------|---------|-------|-----------|---|----------|----------|----|----|
| <b>Acetaminophen</b> (Tylenol) | 500mg   | 650mg | 1000mg PO | <b>Diphenhydramine</b> (Benadryl)       | 25mg     | 50mg     | PO | IV |
| <b>Cetirizine</b> (Zyrtec)     | 10mg PO |       |           | <b>Methylprednisolone</b> (Solu-Medrol) | 40mg IV  | 125mg IV |    |    |
| <b>Loratadine</b> (Claritin)   | 10mg PO |       |           | <b>Hydrocortisone</b> (Solu-Cortef)     | 100mg IV |          |    |    |

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

### MEDICATION ORDER

**Ilumya** (tildrakizumab-asmn) **Dose** 100mg SC **Frequency:** Weeks 0, 4 and then every 12 weeks thereafter  
Every 12 weeks

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Provider Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### SPECIAL INSTRUCTIONS

\_\_\_\_\_

\_\_\_\_\_  
**Provider Name** **Provider Signature** **Date** **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.