



# ILUMYA

(tildrakizumab-asmn)

## PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ M: ☐ F: ☐ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Allergies: \_\_\_\_\_

## PRIMARY DIAGNOSIS

ICD-10 Code: \_\_\_\_\_

## DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- ☐ TB status and date (attach results)

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

## PRE-MEDICATION

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP    |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP    |
| <input type="checkbox"/> Ceterizine 10mg PO      | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO      | <input type="checkbox"/> Other: _____             |

## PRIMARY MEDICATION ORDER

### Dosage

- ☐ ILUMYA (tildrakizumab-asmn) subcutaneous injection  
100 mg

### Patient Weight:

\_\_\_\_\_ lbs  
\_\_\_\_\_ kg

### Frequency

- ☐ Weeks 0, 4, and then every 12 weeks thereafter  
☐ Every 12 weeks

## NOTES

\_\_\_\_\_

## ORDERING PROVIDER

Provider Name: _____	NPI: _____
Practice Name: _____	Phone: _____
Office Contact: _____	Fax: _____
Practice Address: _____	
City, State, Zip: _____	

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_