



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) subcutaenous 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: _____