

# Ilumya (Tildrakizumab-asmn)

**PATIENT INFORMATION**Referral Status (check one):  New Referral  Updated Order  Order Renewal

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

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

**PRESCRIPTION****NURSING**

\* Evaluate patients for tuberculosis [TB] infection prior to initiating treatment with ILUMYA. Initiate treatment of latent TB prior to administering ILUMYA.

**THERAPY ADMINISTRATION**

- Tildrakizumab-asmn** (Ilumya)
- Dose: 100mg
  - Route: subcutaneous injection
  - Frequency:  weeks 0, 4, and then every 12 weeks thereafter /  every 12 weeks
- Patient is required to stay for 30-minute observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

**SPECIAL INSTRUCTIONS****PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

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

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

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

\_\_\_\_\_  
Provider Name (Print)\_\_\_\_\_  
Provider Signature\_\_\_\_\_  
Date