

PRESCRIPTION ORDER FORM

ILUMYA  
(tildrakizumab)



215 Pleasant Street, 5th Floor, Fall River, MA 02721  
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name: Patient's Phone Number:  
Date of Birth: Address:  
Allergies: See List  NKDA  City, State, Zip:  
Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kg Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List
- Tried/Failed Therapies • Negative TB Results • HBV • HAV

PRIMARY DIAGNOSIS

L40.0 Psoriasis vulgaris  Other: \_\_\_\_\_  
 L40.9 Psoriasis, unspecified

LAB ORDERS: PLEASE INCLUDE FREQUENCY

CBC w/ diff & ANC: \_\_\_\_\_  LFT's at month 2 then every 3 months after  Other: \_\_\_\_\_

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

Diphenhydramine 25mg PO or IVP & 50mg PO or IVP  Cetirizine 10mg PO  Pepcid 20mg PO or IVP  
 Solu-Medrol 40mg IVP  Solu-Cortef 125mg IVP  Tylenol 650mg PO  Other: \_\_\_\_\_

PRIMARY MEDICATION ORDER

Ilumya 100mg SubQ at week 0, 4, and every 12 weeks thereafter.  
 Ilumya 100mg SubQ every \_\_\_\_\_ weeks.  
 Other: \_\_\_\_\_  
First Dose:  Y  N  Refill x12 months unless otherwise noted: \_\_\_\_\_

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol  
(See [suitelifehealth.com](http://suitelifehealth.com) for detailed policy)  Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name: Office Contact:  
Address: Phone:  
City, State, Zip:  Fax:  
NPI AND License:  Email:

Provider Signature

Date

