PRESCRIPTION ORDER FORM

ILUMYA

(tildrakizumab)

Suite Life
Infusing health and wellness into your life.

Central Fax: 800-504-0870

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

PRIMARY DIAGNOSIS

☐ L40.0 Psoriasis vulgaris
☐ L40.9 Psoriasis, unspecified
☐ Other: _____

PRE-MEDICATIONS: **No standard premedications typically indicated**

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP
☐ Solu-Medrol 40mg IVP
☐ Solu-Medrol 125mg IVP
☐ Cetrizine 10mg PO
☐ Tylenol 650mg PO
☐ Pepcid 20mg PO or IVP
☐ Other: _____

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

☐ 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 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

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