LIFE SPECIALTY SOLUTIONS

ILUMYA
(tildrakizumab)

PATIENT INFORMATION

PATIENT NAME: ______ PHONE #: ______

ADDRESS: ______ CITY, STATE, ZIP: ______

DATE OF BIRTH: ______ EMAIL: ______

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card
2. History & Physical
3. Patient Demographics
4. Most Recent Labs
5. Medication List
6. Tried/Failed Therapies
7. Negative TB Results

PRIMARY DIAGNOSIS

☐ L40.0 Psoriasis Vulgaris ☐ L40.9 Psoriasis, unspecified

☐ Other ______

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ______

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds for Ilumya

☐ Provider Prescribed: ______

PRIMARY MEDICATION ORDER

☐ Ilumya 100mg SubQ at week 0, 4, and every 12 weeks thereafter.

☐ Other ______

☐ Ilumya 100mg SubQ every ______ weeks.

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ EMAIL: ______

CITY, STATE, ZIP: ______ NPI AND LICENSE: ______

✖ ______ ______

PROVIDER SIGNATURE DATE

LIFE SPECIALTY SOLUTIONS - PHONE: (347) 533-6000 -FAX: (347) 533-7000