



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Psoriasis Vulgaris
 _____ Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. TB Screening Results 3. Copy of the patient's Insurance Card 4. Medications List - Was the patient previously receiving a biologic: Yes No If yes, please include list of previous therapies tried and why they were discontinued., If yes, date therapy was discontinued: _____ If yes, desired wash-out period prior to starting Ilumya: _____ weeks

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: ILUMYA® (tildrakizumab-asmn)
Ilumya: 100 mg

New Start: _____ # Refills (Recommend 5 Refills)

Administer subcutaneously on Week 0, Week 4, and then every 12 weeks thereafter Dispense 1 syringe

Maintenance Dose: _____ # Refills (Recommend 5 Refills)

Administer subcutaneously every 12 weeks Dispense 1 syringe

Pre-Medication Orders: *No pre-medications are recommended based on manufacturer guidelines.*

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

 Physician's NPI#

 Physician's Address

 Prescriber's Signature

 Date