ILUMYA [®] Infusion Form					Referral To: 7-438-9380
	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:			-	
Phone Number:					
Allergies:		_			
Emergency Contact:Primary Diagnosis:Primary Diagnosis:Primary Diagnosis:Primary Primary Pr	soriasis Vulgaris	Phone Number	er:		
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 Phone:		Practice Name: Practice Fax:			
Email: Co-managing Physician:		Office Contact: 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. Presriber'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#	Physici	an's Address			
Prescriber's Signature	}		Date		

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.