ILUMYA®Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	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. 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# Physician's Address

_____ _____

Prescriber's Signature Date