Provider Order Form

ILUMYA (TILDRAKIZUMAB)

PATIENT

Full Name: ____________________ DOB: ____________

Mobile Phone: ____________________ Weight: ______ ☐ lbs ☐ kg

Allergies: ____________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ________ Next Treatment Date: __________

DIAGNOSIS ICD-10 code (must be specified)

☐ Plaque Psoriasis L40.0 ☐ Other: ____________________

PROVIDER

Provider Name: ____________________ Provider NPI: ____________________

Practice Name: ____________________ Referral Coordinator Name: ____________________

Practice Address: ____________________

Phone: ______________ Fax: ______________ Email: ____________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Ilumya (Tildrakizumab), Subcutaneous Injection	☒100 mg	☐ Induction: weeks 0, 4, and then every 12 weeks thereafter ☐ Maintenance: Every 12 weeks

Other:

Refills ☐ Zero ☐ 12 months ☐ ___________ Order valid for 1 year unless otherwise stated. _______________

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX ☐ TB status results

______________________________ ______________________________

Provider Signature Date