Tildrakizumab-asmn (Ilumya)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ L40. ___: Psoriasis

☐ Other: Description:

REQUIRED INFORMATION

☑ TB status & date (list results here & attach clinicals)

_____

THERAPY ADMINISTRATION & DOSING

☑ Administer Ilumya 100mg/1mL subcutaneously in the upper arm, abdomen, or upper thigh.

FREQUENCY *(Choose one)*

☐ Induction: week 0, week 4, followed by every 12 weeks

☐ Maintenance: every 12 weeks

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider if:

- patient reports current infection.
- patient reports recent live vaccine.
- patient reports pregnant or breast feeding.
- Patient must be monitored after the first infusion for 15mins. If no reaction occurs, no further observation required.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, BSA affected

Required Labs: Negative TB within 12 months

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.