immersiv HEALTH

ILUMYA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ L40.0 Psoriasis Vulgaris

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ Negative TB screening within 12 months

MEDICATION ORDER

☐ **LOADING:** Ilumya® (tildrakizumab) 100mg via subcutaneous injection at week 0 and 4

☐ **MAINTENANCE:** Ilumya® (tildrakizumab) 100mg via subcutaneous injection every 12 weeks

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN