

# Ilumya (tildrakizumab-asmn)

Provider Order Form rev. 1/7/2026



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender:  M  F  Other

Email Address: \_\_\_\_\_ Address: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height (in): \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Existing prior authorization?  Yes, (Send a copy)  No (AIC will process)

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

### ICD 10-Code & Description (Provide full completed code)

- L40.0 Psoriasis Vulgaris
- L40.1 Generalized Pustular Psoriasis
- L40.2 Acrodermatitis Continua
- L40.3 Pustulosis Palmaris et Plantaris

- L40.4 Guttate Psoriasis L40.8 Flexural Psoriasis L40.9 Psoriasis, Unspecified
- Other: \_\_\_\_\_

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

### Pre-Medications

- Acetaminophen (Tylenol)  500mg  650mg  1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Loratadine (Claritin) 10mgPO
- Diphenhydramine (Benadryl)  25mg  50mg  PO  IV
- Methylprednisolone (Solu-Medrol)  40mg  125mg IV
- Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### Lab Orders

Required: % BSA affected and areas involved, TB Test Results  
 Other: \_\_\_\_\_

**Ilumya (Tildrakizumab-asmn) SC (Select one):**

#### Loading Dose:

Inject 100 mg at weeks 0 and 4

#### Maintenance Dose:

Inject 100 mg every 12 weeks for one year

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

Refills:  zero  6 months  12 months  \_\_\_\_\_ (Prescription valid for one year, unless otherwise indicated)

**Special Instructions:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PROVIDER INFORMATION

Provider Full Name: \_\_\_\_\_ Provider NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Provider Name (Print)

Provider Signature

Date