Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

ILUMYA INJECTION ORDER
(tildrakizumab-asmn)

Please fax a copy of patient's:

- □ **Demos**
- □ **Current Lab Results**
- □ **Medication List**
- □ **Copy of Insurance Cards**
- □ **TB Results**
- □ **H & P Relevant to Diagnosis**

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

TB Test Result & Date: _____

(Please send copy of TB labs)

Ilumya (tildrakizumab-asmn) Dosage:

100 mg/mL subcutaneous injection

Weeks 0, 4, and every 12 weeks thereafter.

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office Phone Number: _____ Office Fax:_____

Office Address: _____Contact Person: _____