RED RIVER HEALTH
Ambulatory Infusion Clinic

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Ilumya (Tildrakizumab-asmn) Injection Order

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ L40.0 Psoriasis vulgaris ☐ _____ _____
(other)

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress Notes supporting diagnosis *(please attach)*

ILUMYA ORDERS:

Dosing: ☑ 100mg prefilled syringe, SQ

Frequency: ☐ **Initial Dosing**: Week 0, Week 4, then every 12 weeks

☐ **Maintenance Dosing**: Every 12 weeks

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: