Checklist for Ilumya (tildrakizumab-asmn) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____**NPI:**_____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
    - Note should include any therapies tried/failed, and must include discussion about Ilumya
    - Medication list and allergies
- ❑ Supporting lab reports/imaging for Ilumya treatment
    - Baseline negative TB screening
- ❑ Iluyma Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Ilumya (tildrakizumab-asmn)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last injection: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s): _____

❑ **NKDA** **Allergies:** _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Other: _____

Ilumya Medication Order

Dosing: ❑ Ilumya 100 mg/mL solution in a single-dose prefilled syringe

Frequency: ❑ Week 0, week 4, then every 12 weeks thereafter

❑ Every 12 weeks

Administration:

- ✓ Administer Ilumya as a subcutaneous injection in the thigh, abdomen, or upper arm
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ In case of reaction, follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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