

ILUMYA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F

Address: _____ Phone: _____ Email: _____

Height (in): _____ Weight (lb): _____ Referral Status: New Updated Renewal

Infusion/ Injection Information

Primary ICD-10 Code: _____ Primary ICD-10 Description: _____

Other ICD-10 Codes: _____ Other ICD-10 Descriptions: _____

Ilumya (Tildrakizumab) Dosing Info:

- Initial 2 Doses: 100mg SubQ at week 0, 4
- Maintenance Dose: 100mg SubQ every 12 weeks

Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies
- TB Results within 12 month (If positive, include negative TSpot and Chest X-Ray)

Premedications:

- Acetaminophen _____ mg
 PO IV
- Cetirizine _____ mg PO
- Diphenhydramine _____ mg
 PO IV
- Hydrocortisone _____ mg IV
- Loratadine _____ mg PO
- Methylprednisolone _____ mg IV
- Other: _____ mg
 PO IV

Ordering Provider Information

Practice Name: _____ Practice Phone: _____ Practice Fax: _____

Practice Address: _____ Referral Coordinator Name: _____

Referral Coordinator Email: _____ Referral Coordinator Phone: _____

Ordering Provider: _____ Provider NPI: _____ Specialty: _____

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name

Provider Signature

Date