REVITALIZE
INFUSION CENTER

Ilumya®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Plaque Psoriasis ICD-10 Code: EA90.0

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Relevant labs and tests
- Required Information:
  - TB screening

Height: _____

Weight: _____

Orders:

Ilumya (tildrakizumab-asmn)

☐ Loading Dose:

Administer 100mg subcutaneously on Week 0 & Week 4 to provide two doses

☐ Maintenance Dose:

Administer 100mg subcutaneously every 12 weeks for one year

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus