ILUMYA™
tildrakizumab-asmn

Horizon
Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION: ☐ L40.0 - Psoriasis vulgaris

***Required Labs: TB within last year (prior to starting only)**

DOSING

☐ Initial Dose: Administer 100mg SubQ at weeks 0 and 4

☐ Maintenance Dose: Administer 100mg SubQ every 12 weeks

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV

☐ Prednisone _____ mg PO

☐ Other _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Prednisone _____ mg PO

☐ Other _____

LABS

Other (specify):

_____

Provider Signature _____ Date _____

For new referrals, please include recent labs and last two office visit notes.

Fax Referrals to: Kentucky (888) 977-0914 I New York (315) 457-4305 I Ohio (888) 977-0914 I Pennsylvania (724) 240-1586