

MEDICATION ORDERS- ILUMYA (TILDRAKIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>
 Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis ICD 10 Code: L40.0 <input type="checkbox"/> Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> % BSA affected and areas involved <input type="checkbox"/> TB Test Results	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score, if available
List Tried & Failed Therapies, including duration of treatment (include phototherapy, biologic, DMARD, topicals): 1) 2) 3) 4)	

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Ilumya 100mg subQ every 12 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: