

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



MEDICATION ORDERS -ILUMYA TILDRAKIZUMAB

Date: _____

Infusion orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

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"/> Patient demographics AND insurance information <input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> % BSA affected and areas involved <input type="checkbox"/> TB Test Results <input type="checkbox"/> Other _____	<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 <input type="checkbox"/> Other _____

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:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____