Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

MEDICATION ORDERS -ILUMYA
TILDRAKIZUMAB

Date: _____

Infusion orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS
☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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	
☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ Patient demographics AND insurance information	☐ Clinical/Progress notes
☐ This signed order form by the provider	☐ Labs and Tests supporting primary diagnosis
☐ % BSA affected and areas involved	☐ Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score, if available
☐ TB Test Results	☐ Other_____
☐ Other_____	

List Tried & Failed Therapies, including duration of treatment (include phototherapy , biologic, DMARD, topicals):

1)
2)
3)
4)

MEDICATION ORDERS	
Initial Dosing	☐ Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	☐ Ilumya 100mg subQ every 12 weeks
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

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

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____