

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
☐ TB Test Results	Global Assessment Score, if available
☐ 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		
Prescriber Name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____