Ilumya Order Form
(tildrakizumab-asmn)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

- ☐ L40.0 Psoriasis Vulgaris
- ☐ L40.1 Generalized Pustular Psoriasis
- ☐ L40.2 Acrodermatitis Continua
- ☐ L40.3 Pustulosis Palmaris et Plantaris
- ☐ L40.4 Guttate Psoriasis
- ☐ L40.8 Flexural Psoriasis
- ☐ L40.9 Psoriasis, Unspecified

Other:

_____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative TB within 12 months.**

PRESCRIPTION

Lab Orders+
Required: Negative TB, annually
+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Ilumya (tildrakizumab-asmn)

Loading Dose:
☐ **SubQ:** Inject 100 mg at weeks 0 and 4

Maintenance Dose:
☐ **SubQ:** Inject 100 mg every 12 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first injection.

Comments: _____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____