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

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 ICD 10 Code: _____
Description _____

Medication Order

ILUMYA (tildrakizumab-asmn)

Loading Dose
☐ **SubQ:** Inject 100 mg at weeks 0 and 4, then q12 weeks x 1 year

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

Lab Orders+
Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

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

Comments:
_____

Required Clinical Documentation

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.

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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