medix infusion

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

REQUIRED: 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

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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