☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

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

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

# MEDICATION ORDERS -ILUMYA
# TILDRAKIZUMAB

**Date:** _____

Mission Medical

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

| REFERRAL STATUS | | |
|---|---|---|
| ☐ New Referral | ☐ Dose or Frequency Change | ☐ Order Renewal |

| INFUSION OFFICE PREFERENCES (Optional) |
|---|
| Preferred Location*: |

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

| DIAGNOSIS AND ICD 10 CODE | |
|---|---|
| ☐ Moderate to Severe Plaque Psoriasis | ICD 10 Code: L40.0 |
| ☐ Other: _____ | ICD 10 Code: _____ |

| REQUIRED DOCUMENTATION | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress notes |
| ☐ Patient demographics AND insurance information | ☐ 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 | |

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 _____