

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067

MEDICATION ORDERS -ILUMYA TILDRAKIZUMAB

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal ☐ Discontinuation

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

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

<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> % BSA affected and areas involved	<input type="checkbox"/> Psoriasis Area and Severity Index (PASI) or Physician
<input type="checkbox"/> TB Test Results	Global Assessment Score, if available
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

List Tried & Failed Therapies, including duration of treatment (include phototherapy , biologic, DMARD, topicals):

1)
2)
3)
4)

MEDICATION ORDERS

Initial Dosing	<input type="checkbox"/> Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Ilumya 100mg subQ every 12 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION

Prescriber Name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____