Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

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

REJUVEINATE

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	
☐ Patient demographics AND insurance information	☐ Clinical/Progress notes
☐ This signed order form by the provider	☐ 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	☐ Other_____
☐ Other_____	

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 _____