☐ *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

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

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

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

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

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

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

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

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
☐ This signed order form by the provider
☐ % BSA affected and areas involved
☐ TB Test Results
☐ Other_____

☐ Clinical/Progress notes
☐ Labs and Tests supporting primary diagnosis
☐ Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score, if available
☐ 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 _____