

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



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# MEDICATION ORDERS -ILUMYA Date: \_\_\_\_\_ TILDRAKIZUMAB

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

REFERRAL STATUS			
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> 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	
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
<input type="checkbox"/> 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 Global Assessment Score, if available
<input type="checkbox"/> TB Test Results	<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 \_\_\_\_\_