



MEDICATION ORDERS- ILUMYA (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

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"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<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
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:

Contact us with questions at: info@rosenursing.net
or call **887.797.4632 / 954.432.8290**

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.