EXPECARE FAMILY CARE | URGENT CARE OF TEXAS

Ilumya Order Form
(tildrakizumab-asmn)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ L40.0 Psoriasis Vulgaris
☐ L40.1 Generalized Pustular Psoriasis
☐ L40.2 Acrodermatitis Continua
☐ L40.3 Pustulosis Palmaris et Plantaris
☐ L40.4 Guttate Psoriasis
☐ L40.8 Flexural Psoriasis
☐ L40.9 Psoriasis, Unspecified
Other: _____

Lab Orders+

Required: Negative TB, annually

+Medix Infusion will draw required maintenance labs unless otherwise directed by Referring Provider

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include Negative TB within 12 months.**

PRESCRIPTION

ILUMYA (tildrakizumab-asmn)

Loading Dose

☐ **SubQ:** Inject 100 mg at weeks 0 and 4

Maintenance Dose

☐ **SubQ:** Inject 100 mg every 12 weeks for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____