MIC | METRO INFUSION CENTER

MEDICATION ORDERS- ILUMYA (TILDRAKIZUMAB)

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

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

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	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ 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	
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		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164