Ilumya (tildrakizumab-asmn)
Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:

☐ Psoriasis vulgaris (ICD-10 L40.0)
☐ Other (ICD-10 _____)

Dose: ☐ 100 mg subcutaneously on weeks 0, 4, and then every 12 weeks thereafter

Refill: ☐ PRN x 1 year OR _____ times

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

Recommended labs prior to initiating therapy: QuantiFERON Gold TB, CBC, CMP, CRP, hepatitis B surface antigen, hepatitis B surface antibody, hepatitis B core antibody, hepatitis C virus antibody, HIV, and pregnancy test

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

Nursing Orders: ☐ Pharmacy to provide nursing services; nursing to administer in the home or at the AIS

☐ May use Burnham's Vital Care anaphylaxis protocol as needed

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		