

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

L40.0 Psoriasis Vulgaris Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION

DOSE

DIRECTIONS/DURATION

Ilumya® (tildrakizumab)

100mg

Initial: Inject SubQ at Weeks 0 and 4, then every 12 weeks x 1 year
 Maintenance: Inject SubQ at every 12 weeks x 1 year

Is patient currently receiving therapy above from another facility? NO YES

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS:

Labs to be drawn by: Infusion Center Referring Physician

No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:

No premeds ordered at this time Diphenhydramine 25mg PO Other: _____
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS (required)

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)

▪ Annual TB screening to be done by: Infusion Center Referring Physician

Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizumab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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