Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Ilumya® (tildrakizumab-asmn) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NDKA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	L40.0 - Psoriasis Vulgaris
☐	_____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
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MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Ilumya® (tildrakizumab-asmn) if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection or surgery.

DOSE/FREQUENCY:

☐ Induction: Administer Ilumya® 100mg as subcutaneous injection to upper arm, thigh, or abdomen at Weeks 0, 4

☐ Maintenance: Administer Ilumya® 100mg as subcutaneous injection every 12 weeks thereafter

SPECIAL ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	