

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Ilumya (tildrakizumab-asmn)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal	

Location Preference (optional)	
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George	

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE	
<input type="checkbox"/> Moderate to severe plaque psoriasis	L40.0
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION (must include)	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Documentation of % BSA affected and areas involved	<input type="checkbox"/> Psoriasis Area and Severity Index (PASI) or physician global assesment score, if available
<input type="checkbox"/> QuantiFERON Gold TB Test Results	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1)	
2)	
3)	

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Ilumya 100mg sub q at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Ilumya 100mg sub q every 12 weeks
Duration:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____

OPTIONAL PREMEDICATIONS and LAB ORDERS	
<input type="checkbox"/> Acetaminophen 650mg PO prior to injection	
<input type="checkbox"/> Diphenhydramine 25mg PO prior to injection	
<input type="checkbox"/> Other Premed or Lab Order with frequency: _____	

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:		Date:	

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.