

Ilumya (tildrakizumab-asmn)

Provider Order Form rev. 5/20/2022



www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:	Patient Email:			
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

L40.0 Psoriasis vulgaris; Plaque psoriasis

Other: _____

MEDICATION ORDER

Ilumya (tildrakizumab-asmn)

Dose: 100mg SC

Frequency:

Weeks 0, 4 and then every 12 weeks thereafter

Every 12 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order