aleracare
advanced infusion centers™

FAX 833.329.4738

Ilumya (tildrakizumab-asmn)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

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

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (TB Test) Insurance Card (front and back) Current Medications History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): ____________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order