MPP INFUSION CENTERS
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# ILUMYA™ (TILDRAKIZUMAB) ORDER FORM

*(* - Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

____ **New Referral** ____ **Order Renewal** ____ **Medication/Order Change**
____ **Benefits Verification Only** ____ **Discontinuation Order**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| NAME*: | | DOB*: | SEX: ☐ M ☐ F |
| ADDRESS: | | PHONE: | |
| WEIGHT: ☐ LBS ☐ KG | HEIGHT: | EMAIL: | |
| ALLERGIES: | | | |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| PHYSICIAN NAME*: | | PRACTICE NAME: |
| ADDRESS: | | OFFICE CONTACT*: |
| PHONE: | FAX: | EMAIL *(FOR UPDATES)*: |

## ILUMYA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

**ICD-10*:** _____

____ **Initial/Reloading Dose and then Maintenance Dose:** 100mg injection at 0, 4, and then every 12 weeks

**OR**

____ **Maintenance Dosing:** 100mg injection every 12 weeks

**Physician Signature*** _____ **Date*(Order is Valid for One Year)** _____
*Infusion will be administered per MPP policy and protocols*

## REQUIRED DIAGNOSIS:

____ Plaque Psoriasis

____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

## REQUIRED DOCUMENTATION CHECKLIST:

____ Patient Demographics
____ Insurance Card/Information
____ Clinical/Progress Notes supporting DX
____ Current Medication List and H&P
____ TB (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*

**Last Infusion/Injection Date:** _____

***NOTES/ADDITIONAL COMMENTS:***

## Locations:

**--------Colorado--------**
___ Lakewood

**---------Florida---------**
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

**----------Texas----------**
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 03/2021