FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

# MEDICATION ORDERS -ILUMYA
# TILDRAKIZUMAB

**Date:** _____

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal |

| INFUSION OFFICE PREFERENCES (Optional) |
|---|
| Preferred Location*: |

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

| DIAGNOSIS AND ICD 10 CODE | |
|---|---|
| ☐ Moderate to Severe Plaque Psoriasis | ICD 10 Code: L40.0 |
| ☐ Other: _____ | ICD 10 Code: _____ |

| REQUIRED DOCUMENTATION | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress notes |
| ☐ Patient demographics AND insurance information | ☐ Labs and Tests supporting primary diagnosis |
| ☐ % BSA affected and areas involved | ☐ Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score, if available |
| ☐ TB Test Results | |

List Tried & Failed Therapies, including duration of treatment (include phototherapy , biologic, DMARD, topicals):

1)
2)
3)
4)

| MEDICATION ORDERS | |
|---|---|
| Initial Dosing | ☐ Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter |
| Maintenance Dosing | ☐ Ilumya 100mg subQ every 12 weeks |
| Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses | |

| PRESCRIBER INFORMATION | | |
|---|---|---|
| Prescrib er Name : | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | | Date: |

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____