

### ILUMYA (Tildrakizumab-asmn) ORDER FORM

#### REFERRAL TYPE

New Referral     
  Order Renewal     
  Restart     
  Frequency Change     
  Dosage Change

#### PREFERRED LOCATION

<input type="checkbox"/> 2730 University Blvd. West   Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road   Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue   Suite 600 Chevy Chase, MD 20815
<input type="checkbox"/> 18111 Prince Philip Drive   Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW   Suite 300 Washington, DC 20006

#### PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight:                      KG                      LBS	Phone:

#### REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

#### ILUMYA ORDER

##### Dosing/Frequency:

Initial: 100mg injection at 0, 4, and every 12 weeks thereafter  
 Continuation: 100mg injection every 12 weeks - (Number of injections already performed \_\_\_\_\_)

##### Diagnosis:

L40.0—Psoriasis Vulgaris

Other Diagnosis: \_\_\_\_\_ ICD-10 Code (Required): \_\_\_\_\_

##### Special Instructions:

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_ *(Order is Valid for One Year)*

#### REQUIRED DOCUMENTATION

##### Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Copy of the patient's insurance card(s) – front and back
- Most recent labs that include values for TB screening (PPD, QFT Gold or TSpot)
- Medication History
- For continuation of treatment, include the last infusion note

***We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.***