ILUMYATM (tildrakizumab-asmn) Order/ Referral Form



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Patient Information					
Patient Name:			Patient DOB:		
Referral Status					
New Referral Restart/0	Continuation	☐ Medication/Order Ch	ange	□D/C	
Diagnosis and ICD 10 Code					
Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0				
Other Diagnosis:		ICD 10 Code:			
Supporting Documentation					
Patient demographics	Clinical/Progress notes supporting primary diagnosis				
Copy of patient insurance card(s) – front & back		Labs and tests including values for TB screening (PPD, QFT, Gold or TSpot)			
Tried and Failed therapies	Current Medication List				
Medication Orders					
☐ Initial Dosing: Ilumya [™] 100mg subQ injection at 0, 4 and every 12 weeks thereafter					
☐ Maintenance Dosing: Ilumya™ 100mg subQ injection every 12 weeks					
Notes (Additional Info)					
Premedication, adverse and anaphylactic reactions, and post injection will be treated per Gamma Therapeutic Center protocol.					
Prescriber Information					
Prescriber Name:			NPI #:		
Office Contact:	Office Phone:		Office Fax:	Office Fax:	
Prescriber Signature:			Date:	(Order is valid for one year)	
My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.					
Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.					

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