ILUMYA™ (tildrakizumab-asmn) Order/ Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

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Greenfield, WI 53228
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www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ 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:
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.