Tildrakizumab-asmn
(ILUMYA)

Redeemer Health
Infusion Therapy Center

PROVIDERS: Please include the following information to expedite the order:
Patient demographics, insurance information, most recent visit notes, TB status, and applicable labs

PATIENT INFORMATION

REFERRAL STATUS ☐New Referral ☐Updated Order ☐Order Renewal

Patient: ______________________ DOB: ______________________

ICD-10: ☐L40.0 ☐L40.9 ☐Other: ____________ Description: ______________________

Allergies: ______________________ ☐NKDA Weight: ______________________ ☐ lb ☐ kg

Patient Status: ☐ New to Therapy ☐ Continuation of Therapy Last Treatment Date: __________ Next Due Date: __________

PROVIDER INFORMATION

Referral Coordinator Name: ______________________ Referral Coordinator Email: ______________________

Ordering Provider: ______________________ Provider NPI: ______________________

Referring Practice Name: ______________________ Phone: ______________ Fax: ______________

Practice Address: ______________________ City: ______________ State: ________ Zip: ________

NURSING

☒ TB status and date (list results and attach documentation)
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☒ Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center

☒ Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures

THERAPY ADMINISTRATION

☒ Tildrakizumab-asmn (ILUMYA)

Dose and frequency:

☐100 mg at weeks 0, 4, and then every 12 weeks thereafter

☐ 100 mg every 12 weeks

Route: subcutaneous injection

Refills: ☐ No Refills ☐ 12 months ☐ ______________

SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.☐

Provider Name (Print): ______________________ **Provider Signature (No Stamps):** ______________________ **Date:** ______________