Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

(TILDRAKIZUMAB)

ILUMYA (INJECTION ORDER)

Name :	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral	Dose or Frequency Change	Order Renewal

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 infomation	Labs and Tests supporting primary diagnosis
% BSA affected abd areas involved	Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score
TB Test Results	

List Tried & Failed Therapies, Including duration of treatment (include phototherapy, biologic, DMARD, tropicals):
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
Refils:	___ X 6months. ___ X 1 year. ______ Doses

PRESCRIBER INFORMATION

Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature		Date:

All information contained in this form is strictly confidential and will become part of the patient's medica record.