Ilumya®

Provider Order Form Rev. 4/2025

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

e PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Plaque Psoriasis (L40.0-L40.4, L40.8-L40.9), ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Ilumya® (tildrakizumab)	100mg	☐ **INITIAL:** Inject SUBQ at Weeks 0 and 4, then every 12 weeks thereafter x 1 year ☐ **MAINTENANCE:** Inject SUBQ every 12 weeks x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has moderate-to-severe chronic plaque psoriasis affecting at least 3% of the body surface area (BSA).

☐ Plaque psoriasis involves sensitive areas or areas that significantly impact daily function (e.g., palms, soles of feet, head/neck, or genitalia)

☐ Patient has had an inadequate response to or is intolerant to phototherapy, topical therapies, or other systemic therapies.

LAB AND TEST RESULTS (required)

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____