



Ilumya (tildrakizumab-asmn)

New Referral Continuing Treatment Medication Order Change

Patient Information:

Name: _____
 Date: _____
 DOB: _____
 SS#: _____
 Phone #: _____
 Email: _____

Physician Information:

Referring Physician: _____
 Address: _____

 Phone #: _____
 Fax #: _____

Medication Orders

Patient Weight: _____ kg Patient Height: _____ inches First Dose Maintenance Dose

Dosing: **LOADING DOSES: 100mg SQ @ week 0, week 4, and every 12 weeks thereafter**
 100mg SQ every 12 weeks

Premeds(if applicable): _____

Indication / Diagnosis:
 L40. _____

ICD-10 (Required) _____

MD Signature: _____ **NPI#:** _____ **Date:** _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

Main Office
 Bay Ridge - Brooklyn
 9711 3rd Avenue
 Brooklyn, NY 11290
 Phone: 718-400-9924 Fax: 718-586-5146
 newpatient@bhinfusion.com