Allergy, Asthma & Immunology Center, P.C.
Infusion Services

www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

ILUMYA™ (TILDRAKIZUMAB) ORDER FORM

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

(- Required Fields)*

_____ New Referral _____ Order Renewal _____ Medication/Order Change
_____ Benefits Verification Only _____ Discontinuation Order

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

ILUMYA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ________________________________

Initial/Reloading Dose and then Maintenance Dose:
____ 100mg injection at 0, 4, and then every 12 weeks

OR

____ **Maintenance Dosing:** 100mg injection every 12 weeks

Physician Signature* ________________________________

Date*(Order is Valid for One Year) ____________________
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Plaque Psoriasis

_____ Other___________________________

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ TB (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*

Last Infusion/Injection Date: ____________________

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency ______________________________

NOTES/ADDITIONAL COMMENTS:

Locations:

-------Oklahoma-------

___ Tulsa

REVISION DATE- 14/2020