O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Ilumya (Tildrakizumab) Injection

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal
Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:		Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	REQUIRED DOCUMENTATION
☐ Moderate to Severe Plaque Psoriasis ICD 10 Code: L40.0 ☐ Other: _____ ICD 10 Code: _____	☐ This signed order form by the provider ☐ Patient demographics AND insurance information (copy of cards) ☐ Clinical/Progress notes ☐ Lab and Tests supporting primary diagnosis ☐ TB Test Results ☐ % BSA affected areas involved ☐ Psoriasis area and severity index (PASI) or Physician Global Assistant Score, if available ☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody ☐ Hepatitis C Test Results

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
Initial Dosing	☐ Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	☐ Ilumya 100mg subQ every 12 weeks
Refills	☐ X6 months X1 year _____ doses

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

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