

ILUMYA (tildrakizumab-asmn) Referral Order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change
(New Order Required) ☐ Benefits Verification Only ☐ D/C Infusions
*indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____

ILUMYA SUBCUTANEOUS INJECTION

- ☐ Initial dose: 100mg week 0, week 4
☐ Maintenance dose: 100mg every 12 weeks

INDICATION/DIAGNOSIS

- ☐ Psoriasis
☐ Other (please specify in notes)

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Referring Physician's Signature

Date

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 12 months)
☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY

01/2019