Ambulatory Infusion Center

Parkway Medical Center
3609 Park East Drive #207
Beachwood, OH 44122

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www.idconsultants.com/aic

MEDICATION ORDERS – ILUMYA (tildrakizumab-asmn)

Date of Referral: ___________________ Office Location: ☐ Beachwood ☐ Middleburg Heights ☐ Painesville

Patient Information

Patient Name: ____ Date of Birth: _______________________________

Address: ____

City: ____________________________________ State: ___________________ Zip Code: __________________

Phone: _____________________________________ WT (kg): _______________ HT (in): ___________________

Diagnosis: __________________________________ ICD10 Code: ____

Allergies: ____

PLEASE FAX SUPPORTING CLINICAL DOCUMENTATION, INCLUDING MEDICAL RECORDS/PROGRESS NOTES, LABS, and INSURANCE INFORMATION (both front and back of the card) ALONG WITH THIS FORM

ILUMYA DOSING

☐ 100 mg SCC at weeks 0, 4 and every 12 weeks thereafter

☐ Premed Orders: ____

☐ Special Needs/ Considerations: ____

Date of last TB test: ____________________________________ Results: ______________________________

If positive, date of negative chest x-ray: ____

Prescribing Physician: ____

Address: ____

Physician Signature: ____ Date: ____________________________

Physician Phone: __________________________________ Fax: _______________________________________

LAB REQUIREMENTS and LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBING PHYSICIANS

SAFE, CONVENIENT, AND COST EFFECTIVE INFUSION SOLUTIONS