



ILUMYA (TILDRAKIZUMAB) INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:	DOB:	Gender:	☐ Female ☐ Male
Address:	City:	State:	ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm Weight: ☐ lbs. ☐ kg
Allergies:			

Diagnosis Code ICD-10 (required):

Diagnosis Description:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy

Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:		Email:
Address:	City:	State: ZIP:
NPI #:	DEA#:	Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Ilumya (tildrakizumab)	☐ 100mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter ☐ 100mg subcutaneously every 12 weeks ☐ Other: _____	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

☐ TB QFT Screening yearly (optional)

Required labs to be drawn by: ☐ LIVbetter ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing LIVbetter Infusions, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:



COMPREHENSIVE SUPPORT FOR ILUMYA (TILDRAKIZUMAB) THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - ☐ Has the patient had a documented contraindication/intolerance or failed trial of a corticosteroids, vitamin D analogs, calcineurin inhibitors, or Anthralin?
 - ☐ Yes ☐ No If yes, which drug(s)? _____
 - ☐ Percent of body surface (BSA) involved: _____ %
 - ☐ Has the patient tried and failed methotrexate? ☐ Yes ☐ No
 - ☐ Does the patient have a contraindication/intolerance or failed trial to any biologics (i.e., Humira, Skyrizi, Tremfya, Cosentyx, Stelara, Cimzia)? ☐ Yes ☐ No
If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **TB screening test (completed within 12 months) - attach results**
 - ☐ **Positive** ☐ **Negative**

*If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)