ILUMYA (tildrakizumab-asmn) Referral Order Form FAX (877) 637-6691

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

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

Vasco Infusion 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)*

***ICD-10** ______________ **required**

NOTES (ADDITIONAL INFO)

______________________ ________
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