INTRAMED Plus
infusion services

# ILUMYA®

## INFUSION & MEDICAL CENTER

**1. Patient Name** _____ **DOB** _____ **Patient Phone/Cell #** _____

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____Psoriasis Vulgaris ICD-10 Code: L40.0 _____

_____Other: ICD-10 Code: _____

Allergies:_____(or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes, labs, test supporting primary diagnosis
- TB Screening Results
- Current medication list:
  - Was the patient previously receiving a biologic: ❑ Yes ❑ No

    If yes, please include list of previous therapies tried and why they were DCed

    If yes, date therapy was discontinued:_____

    If yes, desired wash-out period prior to starting Ilumya: _____weeks

**Patient**
**Weight:** _____ lbs.
**Height:**_____ in.

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**ILUMYA® (tildrakizumab-asmn)** J Code: J3245

**4. Drug Order:**

**Ilumya:** 100 mg

❑ **New Patient**
Administer subcutaneously on Week 0, Week 4, and then every 12 weeks thereafter
Dispense 1 syringe +_____Refills (Recommend 5)

❑ **Ongoing Patient (Maintenance Dose)**
Administer subcutaneously every 12 weeks
Dispense 1 syringe +_____Refills (Recommend 4)

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

| FAX ALL INFORMATION<br>CENTRAL FAX **803.999.1754** | **INFUSION CENTER LOCATIONS**<br>**BERKELEY CHARLESTON COLUMBIA GREENVILLE**<br>**CENTRAL INTAKE PHONE 803.999.1760** |
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