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.

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 (ecommend 5)

❏ **Ongoing Patient (Maintenance Dose)**

Administer subcutaneously every 12 weeks

Dispense 1 syringe +_____Refills (ecommend 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	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**