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 (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 CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337

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