

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	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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