

## ***Ilumya Request Form***

2301 Evesham Road, Building 800, Suite 115  
Voorhees, New Jersey 08043  
T. (856) 996-0145  
F.(609)751-9799 attn: Stephanie D

<b>DATE:</b>	
<b>Requesting Provider Name and NPI Tax ID#</b>	<b>Name: NPI: Tax ID#</b>
<b>Fax Number</b>	
<b>Practice Contact (Name/Phone number)</b>	
<i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i> <b>Return to Referring Provider (frequency): EVERY _____ WKS / MOS</b>	
<b>Patient Name</b>	
<b>Date of Birth</b>	/ /
<b>Height in ft/in: Weight in lbs:</b>	
<b>Insurance(s): include copies of front and back</b>	
<b>Preferred Treatment Location</b>	<input type="checkbox"/> Voorhees <input type="checkbox"/> Moorestown <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Sewell <input type="checkbox"/> Hamilton <input type="checkbox"/> Galloway
<b>Primary Care Physician (Name / Phone Number)</b>	PCP Name: PCP Phone Number:

Name (last, first) \_\_\_\_\_ DOB: \_\_\_\_\_

**Diagnosis:**

- L40.0 Plaque psoriasis  
 Other: \_\_\_\_\_

**The following information is required for authorization for Ilumya:**

- Proof of patient's negative latent TB test. If the test is positive, proof that the patient has begun therapy for latent TB.
- Is the patient concurrently being treated with any other biologic response modifier, biologic DMARD or other non-biologic immunomodulating agent (such as apremilast)?  YES  NO
- Is the ordering provider a dermatologist or consulted with a dermatologist?  YES  NO
- Has the patient tried and had an inadequate response to a least **ONE** conventional agent (such as acitretin, calcipotriene, cyclosporine, methotrexate, PUVA, tacrolimus, topical corticosteroids) for at least three months, or have an intolerance or contraindication to all conventional treatments?  YES  NO
- Does the patient have moderate-to-severe active plaque psoriasis (eg, >10% BSA, occurrence in delicate areas, intractable pruritus, etc.)?  YES
- Does the patient have psoriasis with concomitant moderate-to-severe psoriatic arthritis?  YES  NO

**PLEASE NOTE:**

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. **\*\* NOTE \*\*** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- Include recent chart notes, tests, labs to support the use of Ilumya.
- **OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS**
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *Please notify our office if medication should be discontinued.*

Ordering Provider Signature: \_\_\_\_\_