

Ilumya Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856) 770-8271 attn: Stephanie D

Is this a Continuation of Care or a new start to the medication?

- ☐ Continuation of Care (Provide documentation of last administration)
☐ New Rx

DATE:	
Requesting Provider Name and NPI Tax ID#	Name: NPI: Tax ID#
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i> Return to Referring Provider (frequency): EVERY _____ WKS / MOS</p>	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	
Preferred Treatment Location	<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

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:
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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.
- **!! IMPORTANT !!** Please notify our office if medication should be discontinued.

Ordering Provider Signature: _____