





2301 Evesham Road - Building 800, Suite 115 Voorhees, New Jersey 08043 T. 866-497-0905 F.(609)-228-9798 Attention: Idyllic Infusion Coordinator

## MEDICATION REQUESTED

DATE:

NAME OF DRUG BEING REQUESTED: Ilumya (ildrakizumab-asmm) (IDYLLIC will be responsible for providing requested drug)

## **REFERRING PROVIDER INFORMATION**

Requesting Provider Name and NPI Tax ID#	Name: NPI: Tax ID#	
Phone Number		
Fax Number		
Practice Contact (Name/Extension)	Phone Number:	Ext:

We will gladly remind your patient to schedule routine follow-up visits with your office.

Return to Referring Provider (frequency): EVERY \_\_\_\_\_ WKS / MOS

# PATIENT INFORMATION

Patient Name		
Date of Birth	/ /	
Height/Weight		
Preferred Treatment Location	⊠ Voorhees ⊠ Wall/Manasquan ⊠ Hamilton	⊠ Moorestown ⊠ Sewell ⊠ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:	





## ALL OF THE FOLLOWING INFORMATION IS REQUIRED

#### **Primary DX Code?**

- □ L40.0 Plaque psoriasis
- □ Other \_\_\_\_\_
- □ 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? \_\_\_\_\_
- □ Is the referring provider a dermatologist or has consulted with a dermatologist? \_\_\_\_\_
- ❑ Has the patient tried and had an inadequate response to at least one conventional agent? (acitretin, calcipotriene, cyclosporine, methotrexate, PUVA, tacrolimus, topical corticosteroids)for at least 3 months, or have an intolerance or contraindication to all conventional treatments? \_\_\_\_\_
- □ Does the patient have severe active plaque psoriasis (>10% BSA, occurrence in delicate areas, intractable pruritus, etc)? \_\_\_\_\_
- Does the patient have psoriasis with concomitant severe psoriatic arthritis? \_\_\_\_\_
- □ Copy of medication prescription. 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.
- □ Copy of Primary and Secondary Medical/Pharmacy Insurance Cards (Please enclose both FRONT & BACK)
- □ Most recent chart notes and, if available, last history and physical. All relevant scans, tests and lab results.
- □ History of Infusion / Injection treatments (if applicable)
- □ Does this patient require premedication(s)? If so, please document premedication requirements.
- Is this patient ambulatory Yes / NO
  Is a wheelchair required Yes / NO

#### PLEASE NOTE:

- 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
- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.
- Please contact our office if medication will be discontinued.

ARBDA/IDYLLIC NPI: 1427622661