Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

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 address:**	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	❒ Voorhees ❒ Moorestown ❒ Wall/Manasquan ❒ Sewell ❒ Hamilton ❒ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

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The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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 modate-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.

❒ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____