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

IDYLLIC
infusion treatment center

# ILUMYA

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

**ARBDA/IDYLLIC NPI:** 1427622661 **TAX ID:** 85-1604336

| **MEDICATION REQUESTED** | |
|---|---|
| **DATE**: | |
| ☐ **New Start**<br>☐ **Continuation of therapy** | |
| **REFERRING PROVIDER INFORMATION** | |
| **Ordering Provider** | **Name:** |
| **Practice Contact (Name/Extension/email)** | **Phone number:**<br>**Email address:** |
| *We will gladly remind your patient to schedule routine follow-up visits with your office.*<br><br>**Return to Referring Provider (frequency): EVERY _____ WKS / MOS** | |
| **PATIENT INFORMATION** | |
| **Patient Name** | |
| **Date of Birth** | / / |
| **Preferred Treatment Location** | ☒ Voorhees ☒ Moorestown<br>☒ Sewell ☒ Hamilton<br>☒ Galloway ☒ Brick |
| **Primary Care Physician (Name / Phone Number)** | PCP Name:<br>PCP Phone Number: |

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## 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? _____
- ❑ 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 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.

***PLEASE NOTE:***

- *Please notify your patient that our office will contact them when we are ready to schedule. Our office will provide & dispense all required medications and obtain all necessary prior authorizations. Please contact our office if medication will be discontinued.*

- ☐ Administer 100mg Tildrakizumab-asmn (Ilumya) subcutaneously weeks 0,4, and then every 12 weeks thereafter
- ☐ Administer 100mg Tildrakizumab-asmn (Ilumya) subcutaneously every 12 weeks
- ☐ Patient is required to stay for 30-minute observation

Refills:_____ (If not indicated order will expire one year from date)
Date:_____
Provider Signature:_____
NPI:_____