Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: _____

STANDARD Ilumya® (tildrakizumab-asmn) Plan of Treatment

NOTE: Patient ***may be ineligible*** to receive Ilumya® if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis:

□ L40.0 **Psoriasis Vulgaris**

☐ **Other ICD-10**_____**Diagnosis description:** _____

4. Dose/Frequency:

□ Administer 100mg at Weeks 0, 4, and every 12 weeks thereafter.

□ Administer 100 mg every 12 weeks

Administer as subcutaneous injection to upper arm, thigh or abdomen.

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____Date: _____

(Dispense as written) (Substitution permitted)

No Stamp Signatures

Printed Physician's Name with Credentials:_____NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 10/31/18, 12/9/19

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MRN:_____

DOB: _____

Guidelines for Prescribing Ilumya® (tildrakizmab-asmn)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

____ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

____ Include patient demographic information and insurance information. (Copy of insurance cards if available)

____ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

____ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Ilumya® as specified of_____weeks. Last known biological therapy:_____and last date received:_____.

____ Other as requested: _____

Pre-Screening: **(TB screening results must be available prior to start of therapy and within last 12 months.)**

____ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

WARNINGS AND PRECAUTIONS

• Hypersensitivity: If a serious allergic reaction occurs, discontinue ILUMYA immediately and initiate appropriate therapy. (5.1) • Infections: ILUMYA may increase the risk of infection. Instruct patients to seek medical advice if signs or symptoms of clinically important chronic or acute infection occur. If a serious infection develops, consider discontinuing ILUMYA until the infection resolves. (5.2) • Tuberculosis (TB): Evaluate for TB prior to initiating treatment. (5.3)

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 10/31/18, 12/9/19