MRN:_____

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 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

☐ Maintenance: 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: _____

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**.

☐ 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

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)

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.