ILUMYA ORDER FORM

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 281-406-1047

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Plaque Psoriasis (ICD-10 Code: L40.0)

☐ Other: _____ (ICD-10 Code: _____)

Allergies

THERAPY ORDER

Initial Dosing (New Start):

☐ 100mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter x1 year

OR

Maintenance Dosing:

☐ 100mg subcutaneously every 12 weeks x1 year

Lab Orders: _____ **Lab Frequency:** _____

☐ Yearly TB QFT screening (optional)

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Curbside Infusion Venture, LLC. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

COMPREHENSIVE SUPPORT FOR ILUMYA THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of a corticosteroids, vitamin D analogs, calcineurin inhibitors, or Anthralin?
    ☐ Yes ☐ No If yes, which drug(s)? _____
  - ☐ Percent of body surface (BSA) involved: _____ %
  - ☐ Has the patient tried and failed methotrexate? ☐ Yes ☐ No
  - ☐ Does the patient have a contraindication/intolerance or failed trial to any biologics (i.e., Humira, Skyrizi, Tremfya, Cosentyx, Stelara, Cimzia)? ☐ Yes ☐ No
    If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ Is the patient or caregiver able to administer Ilumya for self-administration?
  ☐ Yes ☐ No If no, please state reason: _____
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

- ☐ **TB screening test completed within 12 months - attach results**
  ☐ **Positive** ☐ **Negative**

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Curbside Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to 281-406-1047 or call 281-406-1046