

ILUMYA ENROLLMENT FORM

PATIENT INFORMATION

Last Name _____ First Name _____
 Social Security No _____ Date of Birth _____
 Sex M F Weight _____ Height _____
 Home Phone _____ Work/Mobile _____
 Home Address _____
 State _____ Zip _____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____
 Secondary Medical Insurance _____ Medical Insurance Phone _____
 Subscriber Name _____
 Rx Card (PBM) _____ Group No _____
 Prescription Card Bin #: _____ PCN #: _____

TREATMENT ARRANGEMENTS

Start Date: _____ Ship Meds Home Doctor's Office _____ Teaching by: Doctor's Office Other: _____

STATEMENT OF MEDICAL NECESSITY

L40.0 Psoriasis L40.52 Psoriatic Arthritis L41.4 Plaque Psoriasis L73.2 Hidradenitis Suppurative L20.9 Atopic dermatitis L40.8 Moderate to Severe Plaque Psoriasis
 Other: _____ Date of Diagnosis: _____ OR Years With Disease _____

Medication assessment (Within Last 12 Months)

Atopic dermatitis Moderate Moderate to Severe Severe
 Psoriasis Severity: Moderate Moderate to Severe Severe
 Psoriasis Type: Plaque Other: _____

Patient Evaluation:

- Has Patient been diagnosed with Heart Failure? Yes No
- Has Patient been diagnosed with Lymphoma? Yes No
- Does Patient have serious/active infection? Yes No
- Has TB test been performed?
 If yes, results: _____ Comments: _____
- Has Hepatitis B been ruled out or treatment been initiated? Yes No
- Does Patient have latex allergy? Yes No
- Is Patient's platelet count >52,000 cells/uL? Yes No
- Patient Weight: _____ kg/lb
- Allergies: _____ NKDA

Prior (FAILED) Medications:

| Medication | Reason for Discontinuation |
|---|----------------------------|
| Biologics: <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Stelara | _____ |
| <input type="checkbox"/> Others: _____ | _____ |
| <input type="checkbox"/> Methotrexate NA | _____ |
| <input type="checkbox"/> Topicals: _____ | _____ |

Patient Evaluation Cont.



NOTES: _____

PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|--|--|---|--|---------|
| <input type="checkbox"/> ILUMYA® (tildrakizumab-asmn) | <input type="checkbox"/> 100mg/ml Prefilled syringe <input type="checkbox"/> | <input type="checkbox"/> Inject 100mg subcutaneously at week 0, week 4 and every 12 weeks thereafter. <input type="checkbox"/> Others | <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> | |

Physician Signature: x _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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