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: __________________

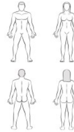
Patient Evaluation:

- 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: ◻ Humira ◻ Enbrel ◻ Stelara	______________________________
◻ Others: ________________	
◻ Methotrexate NA	______________________________
◻ Topicals: ___________	______________________________

Patient Evaluation Cont.



NOTES:____

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PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
◻ **ILUMYA®** (tildrakizumab-asmn)	◻ 100mg/ml Prefilled syringe ◻	◻ Inject 100mg subcutaneously at week 0, week 4 and every 12 weeks thereafter. ◻ Others	◻ 1-month supply ◻ 3-month supply ◻	....

Physician Signature: x____ ◻ **DAW (Dispense as Written) Date:** __________________________

Physician Name: _______________________________ **Phone:** ______________________ **Fax:** ______________________ **Office Contact:** _________________

Physician Address: ____ **NPI:** ________________________ **DEA:** _____________________

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