Hy-Vee health
INFUSION CARE

ILUMYA
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

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:** __________

Patient Weight: __________ lbs. (required) **Allergies:** ____________________

Therapy Order

Initial dosing (New Start):

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

OR

Maintenance dosing:

100 mg 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 *Hy-Vee Health* 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 Hy-Vee Health selecting site of care (if checked, please list site of care): ____________________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other __________

HY-VEEHEALTHINFUSION.COM

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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 not competent or physically unable to administer Ilumya for self-administration? Yes No

Other Medical Necessity: ______________________

Required Prescreening

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+)

Hy-Vee Health 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.

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