Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

ILUMYA MEDICATION ORDER

Please complete all attached pages and submit to Ilumya Support Patient Services Program via fax at 877-872-6575.

The forms must be as complete as possible, and include a clear copy of the patient's insurance cards.

Signatures by the patient and prescriber are required as indicated.

Completing all lines of the Agile order form will significantly ease the authorization process. Once the case is transferred to us, we will contact your office to obtain supporting documentation (including any necessary medical records).

Thank you!

ILUMYA SUPPORT®

Patient Services Enrollment Form

Fax completed pages 1 & 2 with insurance cards
Fax: 877-872-6575 | Phone: 855-4Ilumya (855-445-8692)

The information that you provide will be used by Sun Pharmaceutical Industries, Inc., our affiliates, and our service providers for your patient's enrollment and participation in ILUMYA SUPPORT® Patient Services. Our Privacy Policy governs the use of the information that you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1 Patient Information (*REQUIRED)

***Patient Name**: _____ ***Date of Birth**: ____/____/____ ☐ Male ☐ Female ☐ Other

***Address**: _____ ***City/State/ZIP**: _____

***Mobile Phone**: _____ Alternate Phone: _____ Email: _____

☐ By checking this box, I am requesting my patient be enrolled in the Early Access Program. I understand the patient must be commercially insured to participate and Terms and Conditions apply. Check (all) ***best day**(s) for delivery to prescriber's address: ☐ TU ☐ WE ☐ TH ☐ FR

2 Insurance (*REQUIRED, where applicable)

Patient is: ☐ a US Resident ☐ Uninsured ☐ Has a secondary insurer ☐ Card(s) attached (if checked, proceed to step 3)

	*Primary Insurer	*Secondary Insurer	Pharmacy Insurer
Insurer Name			
Insurer Phone			
Group #			GRP
Policy #			RX BIN
Medicare Beneficiary ID #			RX PCN
If Auth on File, provide reference #			

3 Prescriber (*REQUIRED, where applicable)

***Prescriber Name**: _____

***NPI #**: _____ ***State License #**: _____

Tax ID #: _____ PTAN #: _____

Collaborating MD/DO Name (If applicable):

_____

NPI #: _____

***Clinic Name**: _____

***GRP NPI #**: _____ GRP TAX ID #: _____

***Address**: _____

***City/State/ZIP**: _____

Office Contact: _____

Phone: _____ Fax: _____

4 Obtaining Medication and Alternate Site of Service (*REQUIRED)

***Prefer to obtain by**:

☑ Specialty Pharmacy ☑ Will purchase and bill ☑ Undecided

Indicate here if RX was sent to SP (Name):
Agile Infusion Services will determine if S/P or B&B is best option for plan.

Date: ____/____/____ SP Phone: _____

Indicate below, the alternate site of service† where ILUMYA® will be shipped and administered if different than prescriber's address listed under section 3

Site Name: Agile Infusion Services

Phone: 201-751-2202

Street Address: _____

City/State/ZIP: Web: www.AgeilIV.com Fax: 201-266-0437

†Must have a supervising HCP

5 Prescription and Authorization (*REQUIRED)

Please check the appropriate box:

☐ Patient is a new start: Expected Start Date: ____/____/____

☐ Patient is an existing patient: # Doses: ____ Last Dose Date: ____/____/____

***Primary Diagnostic Code**: ☐ L40.0 ☐ L40.9

***Allergies**: ☐ No known allergies ☐ Yes (please list)_____

_____

***Recent Tb Test (Date)**: ____/____/____ ***Result**: ☐ Positive ☐ Negative

Description: ILUMYA® (TILDRAKIZUMAB-ASMN), 100MG/1ML PREFILLED SYRINGE; SIG, SC: ADMINISTER 100MG (1ML)

☐ Initial dose (week 0) ☐ Week 4 dose ☐ Every 12 weeks

Quantity _____ # of refills _____

By signing below and submitting this form, I certify that: (a) the person named on this form is my patient (the "Patient"); the information provided, to the best of my knowledge, is complete and accurate; and therapy with ILUMYA® is medically necessary for the Patient; (b) my office received the Patient's authorization to release the information above and other of the Patient's protected health information (as defined under the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to SUN PHARMACEUTICAL INDUSTRIES, INC., ILUMYA SUPPORT® Patient Services, the contracted dispensing pharmacy, and other contractors of SUN PHARMACEUTICAL INDUSTRIES, INC. for the purpose of (i) requesting reimbursement support services such as benefits investigation, prior authorization, appeals, and co-pay support; (ii) seeking enrollment of the Patient in the Patient Assistance Program; and (iii) assisting in the Patient obtaining or continuing therapy; (c) product provided at no cost through ILUMYA SUPPORT® Patient Services (if applicable) shall only be used for the Patient, and I will not attempt to, resell, barter, transfer, trade, or return the product for credit, nor will I or my office seek reimbursement for free product provided to the Patient from any third-party payer (private or government, including but not limited to Medicare and Medicaid); (d) my office will maintain any free product separately from commercial inventory and administer the free product only to the Patient; (e) if the Patient is no longer on therapy or otherwise cannot use the free product, I will promptly contact ILUMYA SUPPORT® Patient Services to arrange for product return or disposal; (f) I authorize ILUMYA SUPPORT® Patient Services to transmit the above prescription to the appropriate specialty pharmacy for my patient. (g) I understand that I am under no obligation to prescribe any SUN PHARMACEUTICAL INDUSTRIES, INC. product and that I have not received nor will I receive any benefit from SUN PHARMACEUTICAL INDUSTRIES, INC. for doing so. Special Note: New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.

→ _____
***Original Signature (Dispense as written)** Today's Date

Agile Infusion Locations: (Bergen County) 5 Summit Ave, Hackensack NJ / (Middlesex County) 3 Lincoln Highway, Edison NJ
(Ocean County) 1195 Highway 70, Lakewood NJ

Fax: 1-877-872-6575 | **Phone: 1-855-445-8692** | Indication and Important Safety Information and full Terms and Conditions for the participation in ILUMYA SUPPORT® Patient Services Programs at **www.Ilumya.com**.
See Privacy Policy at **https://sunpharma.com/privacy-policy-new/**

ILUMYA®
tildrakizumab-asmn
Injection 100 mg/mL

ILUMYA SUPPORT®

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6 HIPAA Authorization and Patient Consents (*REQUIRED)

*By signing below, I, _____ _____
Print Patient First Name | Print Patient Last Name | Date of Birth

authorize my healthcare providers ("Providers") and health insurers ("Insurers") to disclose my personal health information, including my medical condition(s), medical history, medical treatments including prescription drugs, and financial information such as my insurance coverage (together, my "PHI") to SUN PHARMACEUTICAL INDUSTRIES, INC., its agents and contractors (together, "Sun Pharma") for purposes of my obtaining services from ILUMYA SUPPORT®. I authorize Sun Pharma to share my PHI with my Providers, Insurers, and Dispensing Pharmacies, to verify, assist with, and coordinate my coverage for ILUMYA® and my eligibility for support program enrollment. I also authorize Sun Pharma to use my PHI to: (i) provide me with educational materials, information, and services related to ILUMYA® and other Sun Pharma medications; (ii) contact me, using my contact information provided on this form, with treatment related communications and to inform me about opportunities to participate in focus groups, surveys, or interviews related to my experience with ILUMYA®; and (iii) if I check the optional 'Consent for Marketing Communications' box below, to provide me with marketing communications. I understand that once my PHI is disclosed to Sun Pharma, certain federal privacy regulations may no longer apply so the PHI could permissibly be re-disclosed, but that Sun Pharma intends to disclose my PHI only as described in this Authorization or as legally required.

I understand that my Providers may receive financial remuneration from Sun Pharma for disclosing PHI to Sun Pharma in accordance with this Authorization. I understand that I do not have to sign this Authorization in order to receive treatment from my Providers or insurance coverage from my Insurers. I also understand that I can revoke this Authorization at any time by calling Sun Pharma at 1-855-4ILUMYA, but that my revocation will not invalidate any uses or disclosures of my PHI before Sun Pharma receives the revocation. This Authorization expires 10 years from the date it was signed, unless I revoke it earlier or applicable state law requires an earlier expiration. I understand that I have the right to receive a copy of this Authorization when it is signed.

_____ _____
Patient Signature or Legal Representative | Today's Date

If Legal Representative: _____ Relationship: _____
Print Name Here

Fair Credit Report Act (REQUIRED for Patient Assistance Program Eligibility)

☐ **By checking this box,** I authorize ILUMYA SUPPORT® Patient Services to obtain information from my credit profile held by Consumer reporting agencies, solely for the purpose of determining financial qualifications for Patient Assistance Program administered by Sun Pharma. I understand that this consent is required in order for Sun Pharma to assess my eligibility. PAP Terms and Conditions apply, see **www.Ilumya.com**.

Marketing Communications Consent (OPTIONAL)

☐ **By checking this box,** I am opting to enroll in LIGHTING THE WAY. I agree to receive optional disease education and other material. I understand providing this agreement is voluntary and plays no role in getting ILUMYA SUPPORT® Patient Services or my medicine. I also understand that I may opt out of receiving this information at any time by calling 1-855-4ILUMYA and that this consent will remain active unless I opt out.

Telephone Consumer Protection Act (TCPA) Consent (OPTIONAL)

☐ **By checking this box,** I consent to receive autodialed calls and text messages from and on behalf of Sun Pharma at the phone number(s) I have provided. I understand that consent is not requirement of any purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling 1-855-4ILUMYA.

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ILUMYA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds* _____

■ **Diagnosis**

☐ L40.0 Plaque psoriasis ☐ _____ Other: _____

■ **Details Needed for Approval** *Please answer all questions and provide supporting documentation.*

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic response modifier, Biologic DMARD or other non-biologic immunomodulating agent (such as apremilast)? _____
- Is the ordering provider a dermatologist or has consulted with a dermatologist? _____
- Has the patient tried and had an inadequate response to a least one conventional agent (such as acitretin, calcipotriene, cyclosporine, methotrexate, PUVA, tacrolimus, topical corticosteroids) for at least three months, or have an intolerance or contraindication to all conventional treatments? _____ *If Yes, please provide comprehensive details.*
- Does the patient have severe active plaque psoriasis (eg, >10% BSA, occurrence in delicate areas, intractable pruritis, etc.)? _____
- Does the patient have psoriasis with concomitant severe psoriatic arthritis? _____

■ **Medication Order**

☐ Initial phase of 100mg Ilumya (ildrakizumab-asmn) SubQ injection at weeks 0 and 4.

☐ Maintenance phase of 100mg Ilumya (ildrakizumab-asmn) SubQ injection every 12 weeks (+/- 5 days) for _____ months.

Note: If maintenance is ordered in addition to the initial phase, the first dose of maintenance will be at week 16.

Allow the Ilumya carton come to room temperature. Choose an injection site per the manufacturer's instructions, inject the full amount in the syringe, and discard in a sharps box.

■ **Rescue Management in Case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437
OR UPLOAD USING THE ONLINE PROVIDER PORTAL AT WWW.AGILEIV.COM