



Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

ILUMYA ORDER

New Start **Maintenance: Last Dose Given**

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____ _____ Height: _____ Weight: _____		

Indication: <input type="checkbox"/> L40.0 Plaque Psoriasis <input type="checkbox"/> Other _____

DRUG: <input type="checkbox"/> Loading doses: 100mg SQ at weeks 0 and 4 then every 12 weeks <input type="checkbox"/> Maintenance only: 100mg SQ every 12 weeks <input type="checkbox"/> Other _____

Prescriber Name:	Title:
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NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____