

**Intravene – Ilumya Infusion Orders (rev 1/2019)**

**Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172**

**PATIENT INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs  
Drug Allergies \_\_\_\_\_  
 NKDA      Sex:  Male or  Female

**REFERRING PHYSICIAN INFORMATION**

Physician Name \_\_\_\_\_  
Physician Address \_\_\_\_\_  
Physician Phone(\_\_\_\_) \_\_\_\_\_  
Physician Fax(\_\_\_\_) \_\_\_\_\_  
NPI# \_\_\_\_\_ DEA# \_\_\_\_\_  
State License# \_\_\_\_\_

**\*\*Please fax copies of insurance cards\*\*  
and this form to 434-455-5531**

**DIAGNOSIS: (ICD-10 required)**

**Moderate to Severe Plaque Psoriasis**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PRE TREATMENT SCREENING:**

- Tuberculosis Screening: Date/Results of TB test \_\_\_\_\_
- Hepatitis B Screening: Date/ Results: \_\_\_\_\_
- Hepatitis C Screening: Date/Results: \_\_\_\_\_

**STANDARD ORDERS:**

Dispense: Ilumya 100mg Subcutaneously at 0, 4 then every 12 weeks.  
Duration:  1 year  other \_\_\_\_\_

**LABS:**

- None
- Other \_\_\_\_\_

**Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol**

**Signature, prescribing MD \_\_\_\_\_ Date: \_\_\_\_\_**