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. 3001

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#_____

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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: _____