

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
ALLERGIES:  SEE LIST  NKDA WEIGHT:  LB OR  KG

**REQUIRED DOCUMENTATION**

1. Insurance Card      2. History & Physical      3. Patient Demographics      4. Most Recent Labs      5. Medication List  
6. Tried/Failed Therapies      7. Negative TB Results

**PRIMARY DIAGNOSIS**

L40.0 Psoriasis Vulgaris       L40.9 Psoriasis, unspecified  
 Other \_\_\_\_\_

**LABS ORDERS: PLEASE INCLUDE FREQUENCY**

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

**PRE-MEDICATIONS**

Per infusion clinic protocol: There are no recommended standard pre-meds for Ilumya  
 Provider Prescribed: \_\_\_\_\_

**PRIMARY MEDICATION ORDER**

Ilumya 100mg SubQ at week 0, 4, and every 12 weeks thereafter.       Ilumya 100mg SubQ every \_\_\_\_\_ weeks.  
 Other \_\_\_\_\_      FIRST DOSE?:  Yes  No  Refill x12 months unless otherwise noted.

**ADVERSE REACTION & ANAPHYLAXIS ORDERS**

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See [lifespecialtysolutions.com](http://lifespecialtysolutions.com) for detailed policy)  
 Other: (Please send other reaction orders if checking this box)

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
OFFICE CONTACT: \_\_\_\_\_ FAX: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ NPI AND LICENSE: \_\_\_\_\_

**X**

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_