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Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

ILUMYA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies: _____

Height: _____ Weight: _____

Indication:

☐ L40.0 Plaque Psoriasis

☐ Other _____

DRUG:

☐ Loading doses: 100mg SQ at weeks 0 and 4 then every 12 weeks

☐ Maintenance only: 100mg SQ every 12 weeks

☐ Other _____

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

Referrals will not be processed until we receive <u>ALL</u> 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: _____