

January 2026



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 <input type="checkbox"/> NKDA <input type="checkbox"/> 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 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: \_\_\_\_\_