



ILUMYA ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____ lbs OR _____ kg
Therapy Status	Provider Information
New Start Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Ilumya	Initiation: Inject 100mg subcutaneously at weeks 0 and 4. Maintenance: Inject 100mg subcutaneously every 12 weeks.	<i>Refills x one year from date of signature unless indicated below.</i> <input type="checkbox"/> _____ Refills	<i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i> <input checked="" type="checkbox"/> <i>Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months.</i>
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PRE-MEDICATIONS

<input type="checkbox"/> Acetaminophen: ___ 325mg ___ 500mg ___ 650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: ___ 25mg ___ 50mg <input type="checkbox"/> Famotidine: ___ 20mg ___ 40mg <input type="checkbox"/> Ibuprofen: ___ 200mg ___ 400mg ___ 600mg <input type="checkbox"/> Ondansetron: ___ 4mg ___ 8mg <input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone: ___ 4mg ___ 8mg <input type="checkbox"/> Diphenhydramine: ___ 25mg ___ 50mg <input type="checkbox"/> Famotidine: ___ 20mg ___ 40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: ___ 4mg ___ 8mg <input type="checkbox"/> Other _____
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LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ Prescriber Name Date	_____ Prescriber Name Date