



NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis		ICD 10 Code: L40.0	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> % BSA affected and areas involved <input type="checkbox"/> TB Test Results *Patient may be required to submit a pregnancy test prior to treatment		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Psoriasis Area and Severity Index (PASI) or Physician Global Assessment Score, if available	
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
4)			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht:	Wt (in kg):
			BMI:
Initial Dosing	<input type="checkbox"/> J3245 Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter		
Maintenance Dosing	<input type="checkbox"/> J3245 Ilumya 100mg subQ every 12 weeks		
Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:		Office Fax:	Office Email:
Prescriber Signature:		Date:	Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
 Ph. 217-258-4150
 217-342-7500
 Fax Completed Form and all documentation to: Fax 217-342-7499