Sarah Bush Lincoln

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

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Moderate to Severe Plaque Psoriasis ICD 10 Code: L40.0

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ % BSA affected and areas involved
- ☐ TB Test Results

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Clinical/Progress notes (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis
- ☐ 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	☐ J3245 Ilumya 100mg subQ at week 0 and 4, then every 12 weeks thereafter
Maintenance Dosing	☐ J3245 Ilumya 100mg subQ every 12 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **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:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
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