AYSA
THERAPEUTICS INFUSION

ILUMYA ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Plaque Psoriasis ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ TB test attached (PPD, QFT, or chest x-ray)

☐ Clinical/progress notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

ILUMYA INJECTION ORDERS

Initial Dosing (New Start)

☐ 100mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter

OR

Maintenance Dosing

☐ 100mg subcutaneously every 12 weeks

**** Once we receive the necessary documentation, we will schedule the patient's treatment.**

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____