



Select referral location:

Akron	Columbus (East Broad)	Findlay	Toledo
Athens	Columbus (Hilliard)	Liberty	Crestview Hills (NKY)
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	
Cleveland	Dayton (Englewood)	Springfield	

Ilumya Order Form

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy	Next due date (if applicable):

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:	NPI#:
License #: TIN#:	DEA#:
Address:	
City:	State Zip
Office Contact:	Email:
Office phone:	Office fax:

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Plaque Psoriasis () ICD 10 () Other: ***TB required prior to initial infusion**

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

ILUMYA	PRE-MEDICATIONS N/A
Initial Dose: Administer 100mg SubQ at weeks 0 and 4	Acetaminophen 500mg 650mg 1000mg
Maintenance Dose: Administer 100mg SubQ every 12 weeks	Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Vital signs per HI Protocol	Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
Anaphylaxis & Hydration Management per HI Protocol	Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
	Prednisone _____ mg PO
	Other _____
	POST-MEDICATIONS N/A
	Acetaminophen 500mg 650mg 1000mg
	Prednisone _____ mg PO
	Other _____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE