



Northwest Rheumatology Associates, P.C.
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Telephone: (503) 297-3384 - Fax: (503) 297-0863
www.nwrheumatology.org

ILUMYA INJECTION ORDER

Patient Name: _____ DOB: _____ Date: _____

Patient demographics, (address, phone)

Copy front and back of all insurance cards

For Plaque Psoriasis Only

Dose of Ilumya	Frequency of Doses
<input type="checkbox"/> 100MG	<input type="checkbox"/> Loading doses week 0, 4, then every 12 weeks <input type="checkbox"/> Dose every 12 weeks

Prior to injection confirm the following:

Patient weight: _____ lbs & _____ kgs

Documented plaque psoriasis

ICD-10 Code: _____

CPT Code: J3245

Expires one calendar year from date or: _____

Ordering physician signature: _____

Ordering physician printed name: _____

Ordering physician phone number: _____

Ordering physician fax number: _____

**Please note all boxes must be checked off for us to schedule your patient for treatment.
Please fax this information to (503) 297-0863 Attn: Patient Resource Team
Please call with any questions at (503) 297-3384**