PURE INFUSION SUITES

Fax form to: 1-801-931-2631

you must enter a 1 before the fax number

INFUSION ORDERS ILUMYA

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

ILUMYA Dosing

☐ 100 mg (SQ) subcutaneous at Weeks 0,4, and every twelve weeks: Refills for 1 year

☐ Other dosing:

Refills:

Infusion Reaction Protocol Option (Select one):

☐ Other Reaction Protocol (please attach)

☐ PURE Infusion Reaction Protocol
(Click for the PURE Infusion reaction protocol)

***Please fax most recent TB test date and results.**

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Provider Phone | Provider Fax