MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

ILUMYA™ (TILDRAKIZUMAB) REFERRAL

(- Required Fields)*

_____ STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Referral Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION

NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION

PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

ILUMYA Injection*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

_____ **Initial/Reloading Dose and then Maintenance Dose:** 100mg injection at 0, 4, and then every 12 weeks

OR

_____ **Maintenance Dosing:** 100mg injection every 12 weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
***NPI#**_____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Plaque Psoriasis

_____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ TB (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*

Last Infusion/Injection Date: _____

FOR MPP USE ONLY

Referral Reviewed and Accepted by: _____ *Date approved:*_____
Additional information needed/ notes:

Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

------Oklahoma--------
___ Tulsa

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 01/2022