

Sending a Referral to University of Michigan Health West

Please follow the steps below to send a referral:

1. Review the Required Documentation Checklist below and include listed documents
2. Fill out all fillable fields on the digital form OR print and fill form out manually.
3. Fax completed order form with all required documentation to (616) 475-3118

Required Documentation Checklist

If we do not receive all documents below with your referral or receive an incomplete medication order form, the order will be returned to you. **It may take up to 14 business days for the patient's insurance company to approve or deny our authorization request.*

- Completed Medication Order Form
- Patient Demographics
- Current Medication List and H&P
- Recent Visit Notes
- Lab Results
- Patient's Insurance Card
- Existing Prior Authorization (*if applicable*)

For patients requiring enrollment in co-pay assistance, it is the responsibility of the ordering office to complete and submit enrollment.

The patient will be responsible for submitting an Explanation of Benefits (EOB) and an itemized bill (obtainable through UMH West customer service department) to the co-pay assistance plan.

INFeD (iron dextran) Order Form

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

Allergies: _____ Weight (kg): _____ Height (cm): _____

Primary ICD-10 & Description (required): _____ Secondary ICD-10: _____ Tertiary ICD-10: _____

(required) Demographics, insurance, lab results, meds and recent visit notes are attached.

Does the patient have an existing prior authorization: Yes (please include) No (UMHW to obtain)

PRESCRIBING OFFICE

Contact Name: _____ Contact Phone Number: _____

Ordering Provider: _____ Provider NPI: _____

Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____

CLINICAL HISTORY

Is this referral URGENT (to be administered within 5-7 days)? Yes No

If yes, please list rationale: _____

Does patient have chronic kidney disease? Yes No

If yes, what stage and ICD10 code? _____

Hemoglobin: _____ Date collected: _____ Ferritin: _____ Date collected: _____

Is patient on hemodialysis? Yes No Is patient currently on an erythropoietin product? Yes No

Is patient unable to tolerate, or had inadequate response to oral iron supplements? Yes No

THERAPY ADMINISTRATION

INFeD(iron dextran) IV:

Dose: 1,000 mg

****Note:** (If patient has never been treated with iron dextran, a 25 mg test dose will be administered over 5 minutes and then observed for 1 hour. If patient tolerates test dose, the remaining 975 mg will be administered over 60 minutes)

Frequency: Once

Date of last infusion (if applicable): _____

*Order expires 12 months from ordering date

Additional Notes from Referring Office:

Provider Name (Print)

Provider Signature

Date

UM Health-West Infusion Center