UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

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.

Infliximab
(Remicade, Renflexis, Avsola, Inflectra)
Order Form

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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

Will the patient be receiving other biologic therapy in combination with infliximab? ○ Yes ○ No

If yes to above, please provide rationale for use:

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

TB Verification (check one): ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

Result Date: Result (check one): ○ Positive ○ Negative

LAB ORDERS

Collect: ☐ BMP ☐ CMP ☐ CBC w/ Diff ☐ CBC w/o Diff ☐ CRP ☐ ESR ☐ Hepatic Panel ☐ _____

Lab Frequency: ○ EVERY infusion ○ Every OTHER infusion ○ _____

PRE-MEDICATION ORDERS

○ Diphenhydramine ○ PO or ○ IV ☐ 25mg or ☐ 50mg OR ○ Cetirizine 10 mg PO

○ Acetaminophen PO _____ mg

○ Methylprednisolone IV Push_____ mg OR ○ Hydrocortisone IV Push _____ mg

THERAPY ADMINISTRATION

Infliximab IV:

1) ○ Choose product based on patient's insurance coverage and availability
2) ○ Select a product from the list below (depending on the patient's health plan, choosing a specific drug may necessitate additional communication and the need for us to recommend an alternative infliximab).
   ☐ Renflexis ☐ Remicade ☐ Avsola ☐ Inflectra

Dose: ○ 3 mg/kg ○ 5 mg/kg ○ 7.5 mg/kg ○ 10 mg/kg ○ _____ mg/kg ○ _____ mg

Frequency: ☐ Initial Dose – 0, 2, 6 weeks, THEN ○ q6 weeks ○ q8 weeks ○ q _____ weeks

*If dosing ordered other than indicated by package insert, please provide a letter of medical necessity.

Date of last infusion (if applicable): _____ *Order expires 12 months from ordering date

Provider Name (Print) Provider Signature Date

UM Health-West Infusion Center
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