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.

Injectafer (ferric carboxymaltose)

Order Form

UNIVERSITY OF MICHIGAN HEALTH-WEST
MICHIGAN MEDICINE
Infusion Center

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

Injectafer (ferric carboxymaltose) IV

Dose: ○ 750 mg ○ 15 mg/kg (for patients weighing less than 50kg)

Frequency: q7 days *(must be given 7 days apart)*

Number of Doses: _____

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

Cascade Campus | 4055 Cascade Rd SE | Grand Rapids, MI 49546
p **616.252.5202** | f **616.475.3118** | UofMHealthWest.org