

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.

Orencia (abatacept)

Order Form

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

Will the patient be receiving other biologic therapy in combination with Orencia? 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

Hepatitis B Virus Screening is required before first dose: Copy of Screening Attached

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 _____

THERAPY ADMINISTRATION

Orencia (abatacept) IV:

Dose: 250 mg 500 mg 750 mg 1000 mg _____ mg

Frequency: Initial Dose 0, 2, 4 weeks, THEN every 4 weeks

q4 weeks

q ____ weeks

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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