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.

Prolia (denosumab)
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) The patient's demographics, insurance, lab results, meds and recent visit notes attached

Does the patient has an existing prior authorization: ○ Yes (please provide copy) ○ No (UMHWest to obtain)

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

Practice Address:

CLINICAL HISTORY

Attach most recent DEXA scan results: Date: _____ T-Score: _____

Has the patient previously tried Reclast? ○ No ○ Yes. If yes, specify below:

Is the patient currently taking calcium and vitamin D? ○ Yes ○ No, reason for not taking:

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

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

Does the patient have a diagnosis or history of any of the following? (Check all that apply):

- ☐ Hypocalcemia
- ☐ History of hypoparathyroidism
- ☐ Thyroid or parathyroid surgery
- ☐ Severe renal impairment (CrCl<30)
- ☐ Malabsorption syndromes
- ☐ Recurrent UTI
- ☐ Recent tooth extraction or jaw surgery

☐ NO the patient does NOT have history of any of the above

Serum calcium is required within 3 months of appointment.

Result Date: Lab Result: _____

Contraindicated in patients with hypocalcemia.

THERAPY ADMINISTRATION

Prolia (denosumab) Subcutaneous Injection

Dose: 60 mg

Frequency: Every 6 months for a total of 2 doses per year.

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

Provider Name (Print) Provider Signature Date

UM Health-West Infusion Center
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