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.

Reclast (zoledronic acid)
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: _____

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

Does the patient have routine dental follow up? ○ Yes ○ No Date of last dental exam: _____

Has the patient tried and failed oral bisphosphonates? ○ 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

Labs required within 90 days of appointment.

Result date: _____

Serum Calcium:

Serum Creatinine: _____

Contraindicated in patients with hypocalcemia or creatinine clearance <35mL/min.

PRE-MEDICATION ORDERS

Acetaminophen 650 mg PO given prior to every dose per UMH West protocol.

THERAPY ADMINISTRATION

Reclast (zoledronic acid) IV

Dose: 5 mg

Frequency: Yearly for a total of 1 dose per year.

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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