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.

Rituximab for GPA/MPA (Rituxan, Ruxience, Truxima)

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

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

Has the patient tried corticosteroids? ○ Yes ○ No

Has the patient tried cyclophosphamide? ○ Yes ○ No

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

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

LAB ORDERS

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

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 ○ Hydrocortisone IV Push _____mg

THERAPY ADMINISTRATION

Rituximab IV GPA/MPA

○ Choose product based on patient's insurance coverage and availability **OR**

○ Select a product: ☐ Rituxan (rituximab) ☐ Ruxience (rituximab-pvvr) ☐ Truxima (rituximab-abbs)

Dose: ○ 375 mg/m^2 BSA = _____ mg ○ 1000 mg ○ _____ mg

Frequency: ○ Every _____ weeks x _____ doses.

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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