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.

Stelara (ustekinumab) IV
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

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

Is patient currently prescribed a different biologic medication for treatment of above diagnosis? ○ Yes ○ No

If yes, please list: _____

TB Verification (check one): ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

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

PRE-MEDICATION ORDERS

○ Diphenhydramine ○ PO or ○ IV ☐ 25mg or ☐ 50mg OR ○ Cetirizine 10 mg PO

○ Acetaminophen PO _____ mg

○ Methylprednisolone IV Push _____ mg OR ○ Hydrocortisone IV Push _____ mg

THERAPY ADMINISTRATION

Stelara (ustekinumab) IV

Dose: ○ 260 mg (55kg or less) ○ 390 mg (55-85kg) ○ 520 mg (more than 85kg)

Frequency: ○ Once

Date of last infusion (if applicable): _____

*Order expires 12 months from ordering date

Ordering subcutaneous injections for maintenance therapy at UMH West?: ○ Yes (please fill out next page) ○ No

*If Yes, UMH West will conduct a benefits investigation for eligibility for in-office injections

_____ _____ _____

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

Stelara (ustekinumab)
Subcutaneous Injection
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

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

Is patient currently prescribed a different biologic medication for treatment of above diagnosis? ○ Yes ○ No

If yes, please list: _____

TB Verification (check one): ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

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

THERAPY ADMINISTRATION

Stelara (ustekinumab) Subcutaneous Injection

UMH West will perform a benefits investigation for eligibility for in-office injections.
**Referring office will be notified if patient is not eligible for in-office injections.*

Dose: _____ mg

Frequency:

Initial Dose: ○ Week 0, 4 and THEN every _____ weeks

Maintenance Dosing Dose: ○ q8 weeks ○ q12 weeks ○ q _____ weeks

Date of last injection (if applicable): _____

Date of induction IV infusion of Stelara (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