INFUSION CENTERS OF MICHIGAN
Helping you heal one infusion at a time

Phone: (855) 831-0870
Metro Detroit Fax: (248) 844-9768
Lansing Fax: (517) 351-3327
InfusionCentersofMichigan.com

Patient Demographics

Patient Name: _____

Patient Phone No: _____

Alternative Phone Number: _____

Patient Insurance: _____ D.O.B. _____

Referring Practitioner: _____ Date. _____

Referring Practitioner Phone No: _____ Fax No. _____

Referral Status

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location Preference

☐ **Macomb Township**
48801 Romeo Plank Rd
Ste. 105
Macomb Township, MI

☐ **Rochester Hills**
1701 E. South Blvd.
Ste. 310
Rochester Hills, MI

☐ **East Lansing**
1650 Ramblewood Dr.
2nd Floor
East Lansing, MI

Diagnosis: _____

Required Documentation

☐ Patient Demographics

☐ Insurance Information and copy of Insurance Card

☐ Clinical Progress Notes

☐ Labs and Tests Supporting Primary Diagnosis

☐ Signature by Provider

Contact Information

All information in this form is strictly confidential and will become part of the patients Medical Record.

Contact us at (855) 831-0870 with any questions

Fax this completed form and required documentation to:

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Comprehensive Support for Allergy and Pulmonology Therapies

PATIENT INFORMATION: Fax completed form, insurance information and clinical documentation

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Please indicate any tried and failed therapies (if applicable):

- ☐ Corticosteroids _____
- ☐ Long-acting beta 2 agonist _____
- ☐ Long-acting muscarinic antagonist _____
- ☐ Immunosuppressants (EGPA) _____

☐ Asthma - Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? Yes☐ No☐

☐ Asthma - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? Yes☐ No☐

☐ If an injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration? Yes☐ No☐

REQUIRED PRE-SCREENING (based on drug therapy)

☐ **CBC with differential-** please attach results (Required for Nucala)

Infusion Centers of Michigan will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility.

Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed.

Thank you for the referral.

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Patient Name:	DOB:
Diagnosis:	DX Code:
Allergies:	Ht/Wt:

MEDICAL INFORMATION:

Patient Weight: _____ lbs/kg required | Allergies: _____

MEDICATION	DOSE	DURATION/REFILLS
Nucala ***Need:*** *CBC w/differential*	☐ 100 mg Sub-Q q 4 weeks ☐ 300 mg Sub-Q q 4 weeks	☐ _____
Pre-Medication Orders	☐ Acetaminophen (Tylenol) 500 mg PO ☐ Acetaminophen (Tylenol) 1000 mg PO ☐ Methylprednisolone (Solu-Medrol) 40 mg IV ☐ Diphenhydramine (Benadryl) 25 mg IV ☐ Other _____ ☐ Loratadine (Claritin) 10 mg PO ☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Methylprednisolone (Solu-Medrol) 125 mg IV	

Provider Signature: _____ Date: _____