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:

Metro Detroit locations Fax: (248) 844-9768 or Lansing Fax: (517) 351-3327

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Comprehensive Support for Dermatology Therapy

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
  - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids) **Yes**☐ **No**☐
    If yes, which drug(s)? _____
  - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of any biologic (i.e., Stelara, Cimza) **Yes**☐ **No**☐
    If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis.

☐ If ***applicable*** - Last know biological therapy: _____
and last date received: _____
Other medical necessity: _____

REQUIRED PRE-SCREENING (based on drug therapy)

- ☐ **TB screening test completed within 12 months** - please attach results (Required for Cosentyx, Infliximab, Ilumya, Simponi Aria) **Positive**☐ **Negative**☐
- ☐ **Hepatitis B surface antigen completed within 12 months -** please attach results (Required for Cosentyx, Infliximab, Ilumya, Simponi Aria) **Positive**☐ **Negative**☐
- ☐ **Hepatitis C Antibody -** please attach results (Required for Cosentyx)
- ☐ **HIV Ab/Ag -** please attach results (Required for Cosentyx)
- ☐ **CBC -** please attach results (Required for Cosentyx, Simponi Aria, Required every 3 months for Infliximabs)
- ☐ **CMP prior to infusion -** please attach results (Required for Cosentyx, Required every 3 months for Infliximabs)
- ☐ **CRP prior to infusion -** please attach results (Required for Cosentyx. Required every 3 months for Infliximabs)

**If TB or Hepatitis B results are positive, provide documentation of treatment, medical clearance, and/or a negative chest x-ray (TB positive only)

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	FREQUENCY	DURATION/REFILLS
Cosentyx ***Need:*** *TB test, Hep B, Hep C, HIV Ab/Ag, CBC, CMP, and CRP*	☐ **Loading Dose:** 6mg/kg IV over 30 minutes at Week 0 ☐ **Maintenance Dose:** 1.75 mg/kg IV over 30 minutes q 4 weeks		☐ _____
Infliximab: (Inflectra, Avsola, Renflexis, Remicade) ***Need:*** *TB test, Hep B, CBC, CMP, and CRP - see pre-screening criteria*	☐ 5mg/kg over 120 minutes ☐ 7.5mg/kg over 120 minutes ☐ 10mg/kg over 120 minutes ☐ _____	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ _____	☐ _____
Ilumya ***Need:*** *TB Test, and Hep B*	☐ **Initial Dose:** 100 mg Sub-Q at 0 and 4 weeks ☐ **Maintenance Dose:** 100 mg Sub-Q at 12 weeks		☐ _____
Simponi Aria ***Need:*** *TB Test, Hep B, and CBC*	☐ **Initial Dose:** 2 mg/kg IV over 30 minutes at weeks 0, 4 and then q 8 weeks ☐ **Maintenance Dose:** 2 mg/kg IV over 30 minutes q 8 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: _____