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 Digestive Health 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 necessities: _____

REQUIRED PRE- AND POST SCREENING (based on drug therapy)

- ☐ **TB screening test completed within 12 months -** please attach results (Required for all biologics) **Positive** ☐ **Negative** ☐
- ☐ **Hepatitis B surface antigen completed within 12 months -** please attach results (Required for all biologics) **Positive** ☐ **Negative** ☐
- ☐ **CBC, CMP, and CRP every 3 months -** please attach results and repeat order every 3 months (Required for all biologics)
- ☐ **Pre-Screening for all Irons within 28 Days-** please attach results (Required for Feraheme, Ferrlecit, Injectafer and Venofer)
  - ☐ **Iron+ TIBC test**
  - ☐ **Ferritin**
  - ☐ **CBC**
- ☐ **Post Infusion Order written for all Irons to be completed at 28 days after final infusion-** Iron+ TIBC, Ferritin, CBC, and Phosphorus.

**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:

MEDICATION	DOSE	FREQUENCY	DURATION/REFILLS
Entyvio ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	☐ 300 mg IV over 30 minutes	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ _____	☐ _____
Feraheme ***Need:*** *Pre-infusion - Iron+ TIBC test, Ferritin, CBC within 28 days.* ***Need:*** *Post-infusion orders - Iron+ TIBC test, Ferritin, CBC, phosphorous 28 days after final infusion*	☐ 510 mg IV over 20 minutes x 2 doses, 7 days apart		☐ _____
Ferrlecit ***Need:*** *Pre-infusion - Iron+ TIBC test, Ferritin, CBC within 28 days.* ***Need:*** *Post-infusion orders - Iron+ TIBC test, Ferritin, CBC, phosphorous 28 days after final infusion*	☐ 125 mg IV over 90 minutes at week 0, then 125 mg IV over 60 minutes q 4 weeks x 6 total doses	☐ 125 mg IV x _____ doses	☐ _____
Hydration ☐ 0.9% NS ☐ Lactated Ringers	☐ 1 liter ☐ Other _____ Over _____ hours	☐ x _____ doses per week ☐ Other _____	☐ _____
Infliximab: (Inflectra, Avsola, Renflexis, Remicade) ***Need:*** *TB test, Hep B, CBC, CMP, 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 ☐ _____	☐ _____
Injectafer: ***Need:*** *Pre-infusion - Iron+ TIBC test, Ferritin, CBC within 28 days.* ***Need:*** *Post-infusion orders - Iron+ TIBC test, Ferritin, CBC, phosphorous 28 days after final infusion*	☐ 750 mg IV over 20 minutes x 2 doses, 7 days apart		☐ _____
Omvoh See diagnosis for method of delivery variance. ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	**Ulcerative Colitis:** ☐ **Induction Doses:** 300 mg IV over 30 minutes at weeks 0, 4, and 8 **Crohn's Disease:** ☐ **Induction Doses:** 900 mg IV over 90 minutes at weeks 0, 4, and 8		☐ _____
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: _____

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

MEDICATION	DOSE	FREQUENCY	DURATION/WEEKS
Pyzchiva ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	**Dosage:** ☐ 260 mg IV over 60 minutes 1x only (up to 55 kg) ☐ 390 mg IV over 60 minutes 1x only (55kg to 85 kg) ☐ 520 mg IV over 60 minutes 1x only (< than 85 kg)		☐ _____
Skyrizi ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	**Ulcerative Colitis:** ☐ **Induction Dose:** - 1200 mg IV over 120 Minutes at weeks 0, 4, and 8. **Crohn's Disease:** ☐ **Induction Dose:** - 600 mg IV over 60 Minutes at weeks 0, 4, and 8.		☐ _____
Tremfya ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	☐ 200 mg IV over 60 Minutes at weeks 0, 4, and 8.		☐ _____
Venofer ***Need:*** *Pre-infusion - Iron+ TIBC test, Ferritin, CBC within 28 days.* ***Need:*** *Post-infusion orders - Iron+ TIBC test, Ferritin, CBC, phosphorous 28 days after final infusion*	☐ 200 mg IV over 15 minutes x 5 doses over 14 days ☐ 200 mg IV over 15 minutes x _____ doses over _____		☐ _____
Yesintek ***Need:*** *TB test, Hep B, CBC, CMP, CRP - see pre-screening criteria*	**Dosage:** ☐ 260 mg IV over 60 minutes 1x only (up to 55kg) ☐ 390 mg IV over 60 minutes 1x only (55kg to 85kg) ☐ 520 mg IV over 60 minutes 1x only (< than 85kg)		
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: _____