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 Other 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 contraindictions to conventional therapy.
- ☐ Include labs and/or test results to support diagnosis.
- ☐ Other medical necessities: _____

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

- ☐ **CBC and CMP within 30 Days-** please attach results. (Required for Adakveo)
- ☐ **B-12 Level within 90 Days-**please attach results. (Required for B-12 Injections)
- ☐ **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-** please attach results Iron+ TIBC, Ferritin, CBC, and Phosphorus.
- ☐ **Magnesium Level within 90 Days-**please attach results. (Required for Magnesium Sulfate Infusion)

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:

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date** _____

MEDICAL INFORMATION:

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

THERAPY ORDER	INFUSION ORDERS	FREQUENCY	DURATION/REFILLS
Adakveo: ***Need:*** *CBC and CMP*	☐ 5 mg/kg IV over 30 minutes on week 0, 2, and q 4 weeks ☐ 5 mg/kg IV over 30 minutes q 4 weeks		☐ _____
B-12 Injections ***Need:*** *B-12 lab within 90 days of injection to prove medical necessity*	☐ 1000 mcg Sub-Q q month x 6 doses. ☐ 1000 mcg Sub-Q q week x 4 doses ☐ Other _____		☐ _____
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 last dose*	☐ 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 last dose*	☐ 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 _____	☐ _____
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 last dose*	☐ 750 mg IV over 20 minutes x 2 doses, 7 days apart		☐ _____
Magnesium Sulfate ***Need:*** *Magnesium levels within 90 days.*	☐ 1 g IV over 60 minutes ☐ _____ g IV over _____ minutes		☐ _____
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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Diagnosis:	DX Code:
Allergies:	Ht/Wt:

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER	INFUSION ORDERS	FREQUENCY	DURATION/REFILLS
Therapeutic Phlebotomy ***Need:*** *CBC, iron panel, and ferritin*	☐ Blood Volume to be removed: _____ ml ☐ No IV fluid replacement ☐ 0.9% NS IV bolus, 250ml, immediately following phlebotomy, over 15 minutes	☐ Q _____ weeks x _____ sessions ☐ Other _____	☐ _____
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 last dose*	☐ 200 mg IV over 15 minutes x 5 doses over 14 days ☐ 200 mg IV over 15 minutes x _____ doses over _____		☐ _____
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: _____