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 Neurology 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 (H & P) to support primary diagnosis
  Has the patient tried and failed previous drug therapy? **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)

- ☐ **Anti-nuclear Antibody and/or Anti-double stranded DNA -** please attach results (Required for Benlysta)
- ☐ **Hepatitis B surface antigen completed within 12 months -** please attach results (Required for Ocrevus Zunovo) **Positive**☐ **Negative**☐
- ☐ **Quantative serum immunoglobins -** please attach results (Required for Ocrevus Zunovo)
- ☐ **LFT Lab -** please attach results (Required for Ocrevus Zunovo and Vyepti)
- ☐ **CBC -** please attach results (Required for Vyepti)
- ☐ **AChR antibody or MuSK antibody -** please attach results (Required for Vyvgart Hytrulo)

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

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

THERAPY ORDER	INFUSION ORDERS	FREQUENCY	DURATION/REFILLS
Benlysta: ***Need:*** *ANA and/or anti-double stranded DNA*	☐ **Initial/Reloading Dosing and then Maintenance Dosing:** 10 mg/kg IV over 60 minutes on 0, 2, 4 weeks and then q 4 weeks. ☐ **Maintenance Dosing Only:** 10 mg/kg IV over 60 minutes q 4 weeks		☐ _____
Ocrevus Zunovo: ***Need:*** *Hep B virus screen, LFT Labs, Quantative serum immunoglobins, and up to date vaccine record of nessicary vaccines.*	☐ 920 mg/23,000 units Sub-Q over 10 minutes q 6 months **Premed protocol:** Dexamethasone 20mg PO & Loratadine 10 mg PO 30 minutes prior to Ocrevus Zunovo		☐ _____
Vyepti: ***Need:*** *LFT, and CBC*	☐ 100 mg IV over 30 minutes q 3 months ☐ 300 mg IV over 30 minutes q 3 months		☐ _____
Vyvgart Hytrulo: ***Need:*** *AChR antibody or MuSK Antibody*	☐ 1,008 mg/11,200 units Sub-Q over 30 to 90 seconds.	☐ weekly for 4 weeks* ☐ weekly for 52 weeks *Cycle may be repeated >50 days from start of previous cycle.	☐ _____
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: _____