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 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**

For patients receiving iron infusions please recheck Iron+ TIBC, Ferritin, CBC, and Phosphorus 28 days after final infusion.

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

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

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, 3-8 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 INFORMATION:	
Patient Name:	DOB:
Diagnosis:	DX Code:
Allergies:	Ht/Wt:

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

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 (greater 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.		☐ _____
Stelara ***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 (greater than 85 kg)		☐ _____
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 ☐ Loratadine (Claritin) 10 mg PO ☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Methylprednisolone (Solu-Medrol) 125 mg IV ☐ Other _____		

Provider Signature: _____ Date: _____

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

Medication	Dose	Frequency	Duration/Weeks
Feraheme IV .9% NS 100 ml over at least 60 minutes. ***Need:** Pre-infusion Iron, TIBC, Iron saturation within 30 days.* ***Need:** Post-infusion - CBC, Iron, TBIC, ferritin, iron saturation, phosphorous 30 days after last dose*	☐ 510 mg - 2 infusions 7 days apart		☐ _____
Pyzchiva IV .9% NS 250 ml over at least 60 minutes. ***Need:** TB Screening with in 12 months*	**Weight Range** ☐ Up to 55 kg ☐ greater than 55 kg to 85 kg ☐ greater than 85 kg	**Dose** ☐ 260 mg ☐ 390 mg ☐ 520 mg	A subcutaneous 90 mg dose 8 weeks after the initial intravenous dose, then q 8 weeks thereafter
Omvoh See diagnosis for method of delivery variance. ***Need:** TB Screening within 12 months Liver and bilirubin lab levels*	**Ulcerative Colitis:** ☐ **Induction Dose:** week 0, week 4, week 8 - IV .9% NS 100 ml over at least 30 Minutes. Dose 300mg **Crohn's Disease:** ☐ **Induction Dose:** - Iv .9% NS 100 ml or 250 ml over 90 Minutes. Dose: 900 mg		☐ _____
Skyrizi See diagnosis for method of delivery variance. ***Need:** TB Screening within 12 months*	**Ulcerative Colitis:** ☐ **Induction Dose:** - IV .9% NS 250 ml over at least 60 Minutes. Dose 600 mg **Crohn's Disease:** ☐ **Induction Dose:** - Iv .9% NS 500 ml over 120 Minutes. Dose: 1200 mg		
Tremfya IV .9% NS 250 ml over 60 minutes	☐ 200 mg	☐ Weeks, 0, 4, 8	

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Diagnosis:	DX Code:
Allergies:	Ht/Wt:

Medication	Dose	Frequency	Duration/Weeks
Infliximab IV 0.9% NS per protocol over 2 hours Annual TB test CBC, CMP q 3 months	☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ _____ **Premeds:** ☐ Claritin 10mg PO prior to infusion ☐ _____	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ _____	
Entyvio IV 0.9% NS 250 ml over 30 minutes Annual TB test CBC, CMP q 3 months	☐ 300 mg **Premeds:** ☐ Claritin 10mg PO prior to infusion ☐ _____	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ _____	
Pyzchiva	**Weight Range (kilograms)** — **Dose** ☐ Up to 55 kg — 260 mg ☐ greater than 55kg to 85 kg — 390 mg ☐ greater than 85k — 520 mg		A subcutaneous 90 mg dose 8 weeks after the initial intravenus dose, then q 8 weeks thereafter
Omvoh	☐ 300 mg over 30 min ☐ 900 mg over 90 min	weeks 0,4 week 8	
Venofer CBC w/diff and iron studies after each infusion	☐ 100mg/100ml over 15 minutes ☐ 200mg/100ml over 15 minutes ☐ 2x 300mg/250 over 1.5 hours + 400mg/250ml over 2.5 hours ☐ Other		
Hydration	☐ 0.9% NS	☐ 1000 ml Over ____ hours	Frequency: _____ x ____ doses
Injectafer IV 0.9% NS 100ml over 20 minutes CBC w/diff and iron studies 30 days after 2nd dose.	☐ 750mg IV x 2 doses, at least 7 days apart		
Ferrlecit IV 0.9% NS 100ml over 90 minutes 1st dose, then over 60 minutes. CBC w/diff and iron studies before each infusion.	☐ 125mg q 4 weeks x 6 doses **Premeds:** ☐ Claritin 10mg PO prior to infusion ☐ Tylenol 1000mg PO prior to infusion	☐ Other	
Skyrizi IV 600 mg given over 1 hour CBC, CMP q 3 months and annual TB test	☐ 600mg per dose (3 induction doses weeks 0, 4, 8)	☐ OBI (6 sub-q doses per year)	
Reclast IV 0.9% NS 100ml over 20 minutes Ca >8.5 Creat Clear> 35ml/min within 3 months Dental/Oral exam q 6 mo.	☐ 5mg ☐ Lab draw: **CMP Date** _____	☐ 1 x/year	x 1 dose
Prolia Sub-q Injections Dexascan (Initial & most recent) Before infusion patient will need Ca lab value Dental/Oral exam q 6 mo.	☐ 60mg Last Dose Date _____ First Dose Date _____	☐ q 6 months ☐ PA # _____ ☐ No PA req'd _____	x 2 dose
Tremfya iv over 60 minutes	☐ 200 mg	☐ Weeks, 0, 4, 8	

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Patient Information: Fax completed form, insurance information and clinical documentation

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- ☐ Include **signed** and **completed** order (MD/prescriber to complete page 1)
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- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
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    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-Infusion Iron within 30 Days-** please attach results and repeat order 30 days post infusion. (Required for Feraheme, Ferrlecit, Injectafer and Venofer)
- ☐ **TIBC within 30 Days-** please attach results and repeat order 30 days post infusion. (Required for Feraheme, Ferrlecit, Injectafer and Venofer)
- ☐ **Iron Saturation within 30 Days -** please attach results and repeat order 30 days post infusion. (Required for Feraheme, Ferrlecit, Injectafer and Venofer)
- ☐ **CBC within 30 Days-** please attach results and repeat order 30 days post infusion. (Required for Feraheme, Ferrlecit, Injectafer and Venofer)
- ☐ **Phosphorus within 30 Days-** please attach results and repeat 30 days post infusion (Required for Feraheme, Ferrlecit, Injectafer and Venofer)

**If TB or Hepatitis B results are positive, provide documentation of treatment or medical clearance and 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.

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