Infusion ASSOCIATES®

Outpatient infusion treatments in a home away from home environment

Sending a Referral to Infusion Associates

Follow the steps below to send a referral to Infusion Associates:

1. Download the desired order form from our website (www.infusionassociates.com/meds).
2. Fill out all fillable fields on the digital version **OR** print and fill form out manually.
3. Fax completed order form with all required documentation listed below to **(833) 996-4888** or **(616) 954-1675**.

Required Documentation Checklist

If we do not receive all documents below with your referral, the order is subject to delays. **It may take up to 14 business days for the patient's insurance company to approve or deny our authorization request.*

- ☐ Completed Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorization *(if applicable)*

How to Use Our Digital Order Forms

1. Upon downloading the desired form, you will see light blue text box, check box, and circle box fields appear. To fill out the form on your computer, click into these fields to type out the necessary patient, office, clinical history, and therapy administration information. You can copy/paste information from the patient's medical record into this form.
2. There is a section at the bottom of each fillable form that allows "Additional Notes from Referring Office" to be added. If you are not finding a field to enter information you need to send over, please put it here.
3. Gather the referring provider's signature to approve the order once you have filled out all fields and send to Infusion Associates via fax.

Apretude (cabotegravir extended release)

Order Form
Rev. 4/12/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ⬭ New Referral ◯ Updated Order ◯ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◯ Yes *(please fax IA a copy)* ◯ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

Date of negative HIV-1 RNA and antibody prior to initiation of treatment: _____ *(please attach results)*

***Negative HIV-1 RNA and antibody test required WITHIN 7 days of EVERY injection.**

THERAPY ADMINISTRATION

Apretude (cabotegravir extended release) Intramuscular Injection

Dose: ◯ 600 mg monthly x 2 doses, then every 2 months thereafter ◯ 600 mg Every 2 months

Date of last injection if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

Provider Name (Print) **Provider Signature** **Date**