

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.

Injectafer (ferric carboxymaltose)

Order Form
Rev. 2/28/2023



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

Is this referral **URGENT** (to be administered within 5-7 days)? Yes No

If yes, please list rationale: _____

Does patient have chronic kidney disease? Yes No

If yes, what stage and ICD10 code? _____

Hemoglobin: _____ Date collected: _____ Ferritin: _____ Date collected: _____

Is patient on hemodialysis? Yes No Is patient currently on an erythropoietin product? Yes No

Is patient unable to tolerate, or had inadequate response to oral iron supplements? Yes No

LAB ORDERS

Infusion Associates provider to order labs per protocol

Labs to be drawn _____ weeks after infusion course is complete:

CBC Iron Studies (Iron, T-sat, TIBC, Ferritin) _____

THERAPY ADMINISTRATION

Injectafer (ferric carboxymaltose) IV:

Infusion Associates provider to dose Injectafer, **OR**

***Monitor serum phosphate levels in patients at risk for hypophosphatemia who require a repeat course of treatment.*

Dose: 750 mg 15 mg/kg (for patients weighing less than 50kg)

Frequency: q7 days (must be given 7 days apart)

Number of Doses: _____

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

Additional Notes from Referring Office:

Provider Name (Print)

Provider Signature

Date