

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

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<u>f we do not receive all documents below with your referral, the order is subject to</u>				
lelays. *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.
- 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.

Nucala (mepolizumab) Order Form

Rev. 3/31/2023

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

PATIENT INFORMATION	N Referral S	Status: ○ New Referral ○ Updat	ed Order ○ Order Renewal		
Date: Patie	ent Name:	DOB:			
Allergies:		Weight (kg):	Height (cm):		
ICD-10 Code(s) & Descri	ption (required):				
		ce, lab results, meds and recent v			
PRESCRIBING OFFICE					
Contact Name:		Contact Phone Number:	Contact Phone Number:		
Ordering Provider:	dering Provider:		Provider NPI:		
Practice Name:	Practice Name:		Fax:		
CLINICAL HISTORY					
For asthma patients ON Does the patient currently	ILY: y use tobacco products?	∘ Yes ∘ No			
What is the patient's peri	pheral blood eosinophil co	ount? cells/mcL; Da	te drawn:		
□ Exacerbation re	ere required for at least 3 esulted in an ED visit and/ ant on high dose ICS/LAB	-			
Drug & Dose	Dates of Use	Drug & Dose	Dates of Use		
THERAPY ADMINISTRA	TION				
○ EGPA: 300mg Frequency: ○ Every 4 we	(age 6-11 years): 40mg ○ HES: 300mg ○ Chroni eeks ○ Every wee ot at IA:	 Severe Asthma (age 12 and olic rhinosinusitis with nasal polypseks 	s: 100mg		
Provider Name (Print)	Provider S	Bignature	 Date		