

## 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](http://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 **(616) 818-4484**.

## 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.

# Veklury (remdesivir)

Order Form

Rev. 04/20/2023



Phone: (833) 394-0600

Fax: (616) 818-4484

## 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

Date of symptom onset: \_\_\_\_\_ (*to qualify patient must be within 7 days of symptom onset*)

(*required*) All lab results are attached.

Date of positive SAR-CoV-2 test results: \_\_\_\_\_

Liver function tests

GFR

### Risk factors if applicable:

BMI > 25 kg/m<sup>2</sup>

Immunosuppressive disease or on immunosuppressive treatment

Sickle cell disease

Neurodevelopmental disorders (e.g., cerebral palsy) or other conditions that confer medical complexity (e.g., genetic or metabolic syndromes and severe congenital anomalies)

Having a medical related technological dependency (e.g., tracheostomy, gastrostomy, or positive pressure ventilation—not related to COVID-19)

Chronic respiratory disease (CF, ILD, COPD, or asthma requiring daily inhaled corticosteroids)

Pregnancy

CKD

Cardiovascular disease (CVA, valvular disease, PAD, CHF, HTN)

Diabetes

## THERAPY ADMINISTRATION

**Veklury (remdesivir) IV** (*for patients  $\geq 12$  years old and  $\geq 40$  kgs*)

Dose: 200 mg on Day 1, and 100 mg on Days 2 and 3.

**Risk of reduced antiviral activity when co-administered with chloroquine phosphate or hydroxychloroquine sulfate.**

**Consider monitoring prothrombin time as clinically applicable.**

RX Expiration Date: \_\_\_\_\_

**Patient may qualify for a clinical trial in which additional therapy is offered.**

You will be notified by research staff if your patient elects to participate and is enrolled.

If you would like more information on the clinical trial, please call: (616) 410-7417.

**Additional Notes from Referring Office:**

\_\_\_\_\_  
Provider Name (Print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date