

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.

Vivitrol (naltrexone) Order Form

Rev.04/20/2023

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

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 The patient has an existing prior authorization: ○ Yes (please fax IA a copy) ○ No (IA will process for y PRESCRIBING OFFICE Contact Name: Contact Phone Number: Ordering Provider: Provider NPI: Practice Name: Phone: Fax: CLINICAL HISTORY Type of addiction: ○ Alcoholism ○ Opioid Dependence 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 THERAPY ADMINISTRATION Vivitrol (naltrexone) Intramuscular Injection Dose: 380 mg Frequency: Once every 4 weeks. Total number of doses: ○ 1 year (13 doses) ○ doses Dates of Use Date of last injection if not at IA: RX Expiration Date: Additional Notes from Referring Office:	ORMATION Refe	NT INFORMATION	PATIE
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