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.

Xolair (omalizumab)

Order Form
Rev. 3/31/2023

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

For patients with Asthma ONLY:

Has compliant use of current maintenance therapy been effective? ○ Yes ○ No

If **No**, please select all that apply:

- ☐ Oral steroids or increase in current maintenance steroid dosing was required
- ☐ Exacerbation resulted in an ED visit and/or hospitalization
- ☐ Increased need for rescue inhaler

Has patient been compliant on high dose ICS/LABA inhaler for at least 3 months? ○ Yes ○ No

What is the patient's blood IgE level prior to starting Xolair? _____ IU/mL; Date drawn: _____

In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

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

Please select the reason that patient is unable to self-inject at home: (fax supporting documentation for exception if applicable)

☐ Prior history of anaphylaxis including to Xolair, or other agents such as foods, drugs, or biologics
☐ Hypersensitivity reactions during the first 3 doses under the guidance of a healthcare provider
☐ Patients or caregivers who are unable to recognize symptoms of anaphylaxis
☐ Patients or caregivers who are unable to treat anaphylaxis appropriately
☐ Patients or caregivers who are unable to perform subcutaneous injections with proper technique
☐ Other: _____

THERAPY ADMINISTRATION

Xolair (omalizumab) Subcutaneous Injection

Dose: ○ _____ mg

Frequency: ○ Every 2 weeks ○ Every 4 weeks ○ Every _____ weeks

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

Additional Notes from Referring Office:

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