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.

Stelara (ustekinumab) IV

Order Form
Rev. 4/5/2023

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

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

Is patient currently prescribed a different biologic medication for treatment of above diagnosis? ○ Yes ○ No

If yes, please list: _____

TB Verification *(check one)*: ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

Result Date: _____ Result *(check one)*: ○ Positive ○ Negative

PRE-MEDICATION ORDERS

○ Diphenhydramine ○ PO or ○ IV ☐ 25mg or ☐ 50mg **OR** ○ Cetirizine 10 mg PO

○ Acetaminophen PO _____ mg

○ Hydrocortisone IV Push _____ mg **OR** ○ Methylprednisolone IV Push _____ mg

THERAPY ADMINISTRATION

Stelara (ustekinumab) IV

Dose: ○ 260 mg *(55kg or less)* ○ 390 mg *(55-85kg)* ○ 520 mg *(more than 85kg)* ○ _____ mg

Frequency: ○ Once ○ Every _____ weeks

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

Ordering subcutaneous injections for maintenance therapy at IA?: ○ Yes (please fill out next page) ○ No

**Infusion Associates will perform a benefits investigation for eligibility for in-office injections.*

Additional Notes from Referring Office:

_____ _____ _____

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

Stelara (ustekinumab) Subcutaneous Injection

Order Form
Rev. 4/5/2023

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Phone: (833) 394-0600
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PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

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PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

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If yes, please list: _____

TB Verification *(check one)*: ☐ TB Skin Test ☐ TB Spot/Quantiferon Blood Test ☐ Chest X-Ray

Result Date: _____ Result *(check one)*: ○ Positive ○ Negative

THERAPY ADMINISTRATION

Stelara (ustekinumab) Subcutaneous Injection*

**Infusion Associates will perform a benefits investigation for eligibility for in-office injections.*

Dose: _____ mg

Frequency:

Initial Dose: ○ Week 0, 4 and THEN every _____ weeks

Maintenance Dosing Dose: ○ q8 weeks ○ q12 weeks ○ q _____ weeks

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

Date of induction IV infusion of Stelara (if applicable): _____

Additional Notes from Referring Office:

_____ _____ _____

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