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.

Leqembi (lecanemab-irmb)

Order Form

Red boxes are required

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 957-2188

PATIENT INFORMATION	Referral Status: ○ New Referral ○ Updated Order ○ Order Renewal
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 and Dose	Dates of Use	Drug and Dose	Dates of Use

- ☐ *(required)* PET scan or CSF results with amyloid beta confirmation
- ☐ *(required)* Recent MRI of brain (within past year)
- ☐ *(required)* Results of cognitive assessment with score ______ (MMSE 22-30,CDR-GS 0.5 or 1)
- ☐ *(required)* Letter of medical necessity
- ☐ *(required)* Repeat brain MRI **MUST** be obtained prior to infusion 5, 7, and 14.
- ☐ *(required for patients covered by Medicare or Medicare Advantage)* I attest that this patient is enrolled in a CMS approved registry for Alzheimer's Disease. I am including a copy of the email confirmation of the CMS registry enrollment that includes the Submission Number or a screenshot of the Submission Number from CMS - https://qualitynet.cms.gov/alzheimers-ced-registry

Name of Registry or Clinical Trial: ______ NCT#: ______

THERAPY ADMINISTRATION	
Leqembi (lecanemab-irmb) IV	
Dose: 10 mg/kg	
Frequency: Every 2 weeks	
Date of last infusion if not at IA:	RX Expiration Date:

Additional Notes from Referring Office:

Provider Name (Print)	Provider Signature	Date