AOM Infusion
Improving Health, Enhancing Life

Pulmonology Infusion Referral Form

Fax To: 800-528-9860
Phone: 800-746-9089
Website: aominfusionrx.com

Patient Demographic Information

Last Name:		First Name:	
Address:		Apt #:	
City:		State:	Zip:
Primary Phone:		Alt Ph or Email:	
Height:	Weight (kg):	Sex: ☐ Male ☐ Female	DOB:
Emergency Contact:		Phone:	

Insurance Information

Primary Insurance Provider:	Policy Number:
Phone Number:	Group:
Secondary Insurance Provider:	Policy Number:
Phone Number:	Group:
Employer Name:	Phone Number:

Diagnosis/General Information

Allergies: _____

Pertinent Clinical History: _____

Patient Status (select one):

☐ New to therapy ☐ Continuation of therapy and last infusion day: _____

Please include the below information in the referral:

☐ Demographics
☐ Insurance Information
☐ Prescription/Order
☐ Clinicals showing infusion need (i.e. progress notes, IgG labs, documentation showing exacerbations, pulmonary function test (PFT), tried and failed medications, etc.)
☐ Labs

Patient Diagnosis, ICD-10 Codes:

☐ D80.1 Hypogammaglobulinemia
☐ D83.9 Common Variable Immune Deficiency w/ recurrent infections
☐ D86.0 Sarcoidosis with pulmonary involvement
☐ J18.9 Chronic recurrent pneumonia
☐ J44.9 Chronic obstructive pulmonary disease with recurrent infections
☐ J45.50 + D80.1 Severe asthma with immunodeficiency
☐ J47.9 + D80.1 Bronchiectasis with immunodeficiency
☐ J84.89 Organizing pneumonia
☐ J84.9 Interstitial lung disease associated with autoimmune disease
☐ M31.30 Granulomatosis with polyangiitis (Wegener's)
☐ M35.81 Antisynthetase syndrome with lung involvement
☐ Other: _____

Prescription Order

☐ **Immunoglobulin**	Administration route (select one): ☐ IV Infusion (IVIG) ☐ Subcutaneous Infusion (SCIG)	Loading Dose: _____ gm/kg over _____ days Maintenance: _____ gm/kg over _____ days every _____ week(s) ☐ Pharmacy to dose
☐ **Alpha-1 Antitrypsin (AAT) infusion product:** Aralast, Glassia, Prolastin, Zemaira		Dosing: Infuse 60 mg/kg IV once weekly
☐ **Fasenra**	☐ Asthma: Fasenra 30mg PFS SQ every 4 weeks X 3 doses, then 30mg PFS SQ every 8 weeks ☐ Eosinophilic granulomatosis w/polyangiitis (Churg-Strauss): Fasenra 30mg PFS SQ every 4 weeks	
☐ **Tezspire**	☐ Asthma or Chronic rhinosinusitis with nasal polyps: Tezspire 210 mg PFS SQ once every 4 weeks	
☐ **Xolair** **Lab requirements: serum total IgE level (IU/mL) measured before the start of treatment as well as patient body weight*	☐ Xolair ____ mg PFS SQ every ____ weeks ☐ Xolair PFS SQ Pharmacist to dose (please provide following details): Patient Weight: _____ Pretreatment Serum IgE (IU/mL): _____ Frequency (Every 2 or 4 weeks): _____	

☐ **Other Infusion Medication (include dosing, frequency, and other pertinent information)**

_____

Pre-Medication Order

Pre-Medication: Premedication and anaphylaxis kit per AOM Infusion protocol unless otherwise stated.

☐ Diphenhydramine ☐ PO or ☐ IV _____ mg, approximately 30 minutes prior to each infusion.
☐ Acetaminophen PO_____mg tablet, approximately 30 minutes prior to each infusion.
☐ Methylprednisolone IV_____mg, approximately 30 minutes prior to each infusion.
☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____
☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____
☐ None

☐ NS 500 ML bolus _____ Other _____ (in case 250 pre and 250 post) ☐ Pre-hydration ☐ Post hydration ☐ Pre and post hydration

Nursing and Lab Orders

Infusion Nursing: RN to provide start of care assessment, place PIV or access CVAD, administer all prescribed medication per Rx, monitor for adverse effects, and teaching until independent with procedure if applicable.

Labs: Lab draw requests will undergo review by the AOM clinical team to assess for current capacity and clinical appropriateness. Please note that we are unable to provide STAT Lab draws or Lab draws on weekends, holidays, or evenings due to specimen stability, logistics, and other considerations.

☐ Lab Order _____ Frequency of Labs: ☐ Once ☐ Every Infusion ☐ Every _____ weeks

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Prescriber Information

Prescriber:		Office Contact Name:		
Clinic/Practice Name:				
Address:		City:	State:	Zip:
Phone:	Fax:	License #:	UPIN #:	NPI:
Patient Last Name:		Patient First Name:		Patient DOB:

Prescriber Signature: _____ **Date:** _____

Substitutions permitted unless "No Substitution" is noted on this form.

By signing this form, you and your practice are consenting to receive communications from AOM Infusion. You authorize AOM Infusion to assist with prior authorization requests acting as your pharmacy provider in dealing with prescription and medical insurance organizations.

This form is not a valid order in the state of Arizona.

CONFIDENTIALITY NOTICE: The information contained in this communication and any additional attachments is confidential information or Protected Health Information (PHI) belonging to the sender and intended only for the use of the individual or entity named above. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this information in error, please notify AOM Infusion immediately at *(800) 556-4246* to arrange for the return or destruction of the original document.

Fax completed form, insurance information, and clinical documentation to: ***800-528-9860***. For any questions, please contact us at ***800-746-9089*** or visit our website ***aominfusionrx.com.***

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