AOM Infusion
Improving Health, Enhancing Life

Rheumatology 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: progress notes and diagnostics (i.e. biopsies, labs, tried and failed medication HX, etc.)
- ☐ Labs
- ☐ Additional Information: _____

Patient Diagnosis, ICD-10 Codes:
- ☐ I77.6 Vasculitis unspecified
- ☐ M05 Rheumatoid arthritis with rheumatoid factor
- ☐ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
- ☐ M06.1 Still's disease
- ☐ M30.3 Kawasaki disease
- ☐ M31.30 ANCA-associated vasculitis
- ☐ M32.9 Systemic lupus erythematosus (SLE)
- ☐ M33.00 – M33.99 Dermatomyositis
- ☐ M33.00 Juvenile dermatomyositis
- ☐ M33.20 – M33.29 Polymyositis
- ☐ M35.0 Sjogren syndrome with systemic involvement
- ☐ M45 Ankylosing spondylitis
- ☐ L40.5 Arthropathic psoriasis
- ☐ 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
☐ **Remicade or other Infliximab product:** Remicade, Avsola, Inflectra, Renflexis, Unbranded Infliximab	☐ _____ mg/kg IV or _____ mg at week 0, 2,6, then every _____ weeks	
☐ **Tremfya**	☐ Plaque Psoriasis: Inject Tremfya 100mg SQ at week 0, 4, and every 8 weeks thereafter ☐ Psoriatic Arthritis: Inject Tremfya 100mg SQ at week 0, 4, and every 8 weeks thereafter	
☐ **Actemra or Biosimilar product:** Actemra, Tyenne	☐ _____ mg/kg IV or _____ mg every _____ weeks	
☐ **Cimzia**	☐ Induction: 400 mg subcutaneously (2 SQ injections of 200 mg) at weeks 0, 2, and 4 ☐ Maintenance dose: _____ mg SQ every _____ weeks	
☐ **Rituxan or other Biosimilar product:** Rituxan, Ruxience, Truxima, Riabni	☐ Rheumatoid Arthritis: 1000 mg IV at week 0 and week 2, then repeat the 2-dose cycle every _____ weeks ☐ Other: _____ mg IV at week 0 and week _____ (leave blank if only one dose), then repeat cycle every _____ 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, 15-30 minutes prior to each infusion

☐ Acetaminophen ☐ PO _____ mg tablet, 15-30 minutes prior to each infusion

☐ Methylprednisolone ☐ IV _____ mg, 20 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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