AOM Infusion
Improving Health, Enhancing Life

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:		Alternate Phone:	
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

Primary Diagnosis:	ICD Code:
Allergies:	

Prescription Information (or attach a copy of the prescription)

Therapy Type:
☐ Remicade ☐ Inflectra ☐ Renflexis ☐ Avsola ☐ Entyvio ☐ IV Stelara ☐ SubQ Stelara 2 - 45mg vials maintenance dose
☐ IV Injectafer ☐ IV Venofer ☐ Other _____

Dose: (Please check one)
☐ Induction Dose: _____mg at week 0, 2, 6 then every 8 weeks (Dose: _____ mg/kg)
☐ Maintenance Dose: _____ mg every _____ weeks (Dose: _____ mg/kg) *Last Dose Given: _____ /_____ /_____
☐ Refills _____

Pre-Medication:
☐ 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

Please Fax Additional Paperwork for CID Patients:
☐ Demographics ☐ Most Recent TB and Hepatitis Test Results ☐ Recent Clinical Notes
☐ Prescription with Dose and Frequency ☐ Prescription for Premeds if needed ☐ Any Lab Orders _____ cycles
☐ Additional Notes:

_____
_____
_____

Labs: Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekend/holidays/evenings. Not appropriate for STAT labs.
☐ Lab Order _____ Frequency of Labs: ☐ Once ☐ Every Infusion ☐ Every _____ weeks
☐ Lab Order _____ Frequency of Labs: ☐ Once ☐ Every Infusion ☐ Every _____ weeks

Physician Information

Prescribing Physician:		Office Contact Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	License #:	UPIN #:	NPI: