

Patient Demographic Information

Name:		Sex: Male Female	DOB:
Address:		City/State/Zip:	
Primary Phone:	Alt Phone:	Height:	Weight:
Emergency Contact:		Phone:	

Diagnosis/General Information

Allergies: _____ Pertinent Clinical History: _____ Patient Status (select one): New to therapy Continuation of therapy and last infusion day: _____	Patient Diagnosis, ICD-10 Codes: D80.0 X-linked agammaglobulinemia D80.1 Hypogammaglobulinemia D80.3 Selective deficiency of immunoglobulin subclasses D83.9 Common Variable Immunodeficiency (CVID) Other: _____
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Please include the below information in the referral:

 Demographics
 Insurance Information
 Prescription/Order

 Clinicals showing infusion need (i.e. progress notes, IgG labs, vaccine challenge, pre and post PNE titers, antibiotic use HX)
 Labs

Prescription Information

Immunoglobulin (IVIG or SQIG)	_____ gm/kg over _____ days every _____ weeks	IVIG	SQIG
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 <i>*Lab requirements: serum total IgE level (IU/mL) measured before the start of treatment as well as patient body weight</i>	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): _____		

Prescription Order

Pre-Medication: Premedication and anaphylaxis kit per AOM Infusion protocol unless otherwise stated. **None**

Diphenhydramine PO or IV _____ mg, 15-30 mins prior to each infusion Methylprednisolone IV _____ mg, 20 mins prior to each infusion

Acetaminophen PO _____ mg tablet, 15-30 mins prior to each infusion Other _____ PO or IV, Strength _____ Directions _____

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

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

Prescriber Information

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

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**.