AOM Infusion
Improving Health, Enhancing Life

Gastroenterology 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:

Prescription Information

☐ **Remicade or other Infliximab product:** Remicade, Avsola, Inflectra, Renflexis, Unbranded Infliximab	☐ Induction Dose: Infuse: _____mg/kg IV on weeks 0, 2, and 6	☐ Maintenance Dose: Infuse: _____mg/kg IV every 8 weeks ☐ Rapid Infusion: may infuse subsequent doses over one hour based on patient tolerability
☐ **Entyvio**	☐ IV Induction Dose: Infuse Entyvio 300mg IV over 30 minutes on weeks 0, 2, and 6	☐ Maintenance Dose: Infuse Entyvio 300mg IV over 30 minutes every 8 weeks ☐ Entyvio Pen Maintenance Dose: After loading dose on week 0 and week 2 of Entyvio 300 mg IV, may switch to 108 mg subcutaneously on week 6 and every 2 weeks thereafter
☐ **Skyrizi**	☐ For Crohn's Disease: Skyrizi 600mg IV over at least 1 hour at week 0, 4, and 8	☐ For Ulcerative Colitis: Skyrizi 1200mg IV over at least 2 hours at week 0, 4, and 8
☐ **Stelara or other Ustekinumab product:** Stelara, Steqeyma, Yestinek, Imuldosea, Selarsdi, Pychiva, or other biosimilar	☐ Induction Dose: Infuse _____ mg/250ml NS IV over 1 hour x 1 dose (UC and Crohn's)	☐ Maintenance Dose: Inject _____mg SQ every _____weeks
☐ **Tremfya (IV and Sub Q) for Ulcerative Colitis**	☐ Induction Dose: Infuse Tremfya 200mg IV over at least one hour with a 0.2 micron filter at week 0, 4, and 8	☐ Maintenance Dose: Inject Tremfya 100mg PFS SQ at week 16 and every 8 weeks thereafter ☐ Maintenance Dose: Inject Tremfya 200mg PFS SQ at week 12 and every 4 weeks thereafter. Use the lowest effective recommended dosage to maintain therapeutic response
☐ **Tremfya (IV and Sub Q) for Crohn's Disease**	☐ Induction Dose IV: Infuse Tremfya 200mg IV over at least one hour with a 0.2 micron filter at week 0, 4, and 8 OR ☐ Induction Dose PFS SQ: 400mg PFS SQ (as 2 consecutive 200mg injections) on weeks 0, 4, and 8	☐ Maintenance Dose: Inject Tremfya 100mg PFS SQ at week 16 and every 8 weeks thereafter ☐ Maintenance Dose: Inject Tremfya 200mg PFS SQ at week 12 and every 4 weeks thereafter. Use the lowest effective recommended dosage to maintain therapeutic response
☐ **Other Infusion medication (include dosing, frequency, and other pertinent information)** _____		
☐ **Injectafer**	☐ Injectafer 750mg IV x 2 doses, separated by at least 7 days	
☐ **Venofer**	☐ Venofer 200mg IV x 5 doses spread over 14 days	

Prescription 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

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

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: notes, diagnostics, colonoscopy, medication list, etc

☐ Most Recent TB and Hepatitis B Test Results

☐ Labs

☐ Additional Information:

_____

_____

_____

Patient Diagnosis, ICD-10 Codes:

☐ K50.0 Crohn's disease of small intestine

☐ K50.1 Crohn's disease of large intestine

☐ K50.8 Crohn's disease of both small and large intestine

☐ K50.9 Crohn's disease, unspecified

☐ K51.0 Ulcerative (chronic) pancolitis

☐ K51.2 Ulcerative (chronic) proctitis

☐ K51.3 Ulcerative (chronic) rectosigmoiditis

☐ K51.4 Inflammatory Polyps

☐ K51.5 Left sided colitis

☐ K51.8 Other ulcerative colitis

☐ K51.9 Ulcerative colitis, unspecified

☐ Other (code and description):

_____

_____

_____

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.

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.***