AOM Infusion
Improving Health, Enhancing Life

Neurology 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: progress notes and diagnostics (i.e. EMG, Lumbar Puncture/Spinal Tap, MRI, nerve-conduction studies, etc.)
- ☐ Labs
- ☐ Additional Information: _____

Patient Diagnosis, ICD-10 Codes:
- ☐ G04.00 – G04.02 Acute disseminated encephalomyelitis (ADEM)
- ☐ G04.81 Autoimmune encephalitis
- ☐ G13.0 Paraneoplastic neurologic syndrome
- ☐ G25.82 Stiff person syndrome
- ☐ G35.A Relapsing-remitting multiple sclerosis
- ☐ G35.B0 Primary progressive multiple sclerosis unspecified
- ☐ G35.B1 Active primary progressive multiple sclerosis
- ☐ G36.0 Neuromyelitis optica spectrum disorder
- ☐ G61.0 Guillain-Barré syndrome (GBS)
- ☐ G61.81 Chronic inflammatory demyelinating polyneuropathy (CIDP)
- ☐ G61.82 Multifocal motor neuropathy (MMN)
- ☐ G70.00 Myasthenia gravis without exacerbation
- ☐ G70.01 Myasthenia gravis with exacerbation/crisis
- ☐ G72.41 Inclusion body myositis
- ☐ G73.1 Lambert-Eaton syndrome
- ☐ M33.00 – M33.99 Dermatomyositis
- ☐ M33.20 – M33.29 Polymyositis
- ☐ Other: _____

Prescription Information

☐ **Immunoglobulin (IVIG or SQIG)**	☐ _____gm/kg over_____days every_____weeks ☐ IVIG ☐ SQIG	
☐ **Briumvi**	☐ Initial: 150mg IV on Day 1, followed by 450mg once 2 weeks later	☐ Maintenance: 450mg IV every 24 weeks (beginning 24 weeks after the 1st dose of 150mg)
☐ **Imaavy**	☐ Initial: 30mg/kg IV X 1 dose	☐ Maintenance: 15mg/kg IV every 2 weeks (starting 2 weeks after the initial dose)
☐ **Ocrevus**	☐ Initial: 300mg IV on Day 1, followed by 300mg once 2 weeks later	☐ Maintenance: 600mg IV every 6 months (beginning 6 months after the 1st 300mg dose)
☐ **Ocrevus Zunovo**	☐ Ocrevus Zunovo 920mg/hyaluronidase 23,000 units SQ once every 6 months	
☐ **SoluMedrol**	☐ Solumedrol_____mg IV daily x_____day	
☐ **Soliris**	☐ Soliris 900 mg IV weekly x 4 weeks, 1200 mg IV on week 5 and every 2 weeks thereafter	☐ If patient less than 40 kg, pharmacist to dose Patient weight: _____
☐ **Ultomiris**	☐ Ultomiris_____mg IV loading dose x1, then _____mg IV two weeks after loading dose and every 8 weeks thereafter	☐ Pharmacist to Dose: (Please fill in patient weight) Patient weight: _____
☐ **Vyvgart**	☐ Vyvgart 10mg/kg IV (Greater than 120kg, dose is 1200mg) once weekly X 4 weeks. Repeat every ____ weeks	
☐ **Vyvgart Hytrulo**	☐ Vial For gMG: 1008mg Vyvgart Hyrtulo alfa/11,200 units hyaluronidase SQ once weekly X 4 weeks. Repeat every ____ weeks	☐ Vial For CIDP: 1008mg Vyvgart Hyrtulo alfa/11,200 units hyaluronidase SQ once weekly

Prescription Information Continued

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

_____

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

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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.***