AOM Infusion | Pulmonology Referral Form

Improving Health, Enhancing Life

Fax To: 800-528-9860
Phone: 800-746-9089
Website: aominfusionrx.com

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: _____

Please include the below information in the referral:

☐ Demographics
☐ Insurance Information
☐ Prescription/Order
☐ Clinicals showing infusion need (i.e. progress notes, IgG labs, documentation showing exacerbations, pulmonary function test (PFT), tried and failed medications, etc.)
☐ Labs

Patient Diagnosis, ICD-10 Codes:

☐ D80.1 Hypogammaglobulinemia
☐ D83.9 Common Variable Immune Deficiency w/ recurrent infections
☐ D86.0 Sarcoidosis with pulmonary involvement
☐ J18.9 Chronic recurrent pneumonia
☐ J44.9 Chronic obstructive pulmonary disease with recurrent infections
☐ J45.50 + D80.1 Severe asthma with immunodeficiency
☐ J47.9 + D80.1 Bronchiectasis with immunodeficiency
☐ J84.89 Organizing pneumonia
☐ J84.9 Interstitial lung disease associated with autoimmune disease
☐ M31.30 Granulomatosis with polyangiitis (Wegener's)
☐ M35.81 Antisynthetase syndrome with lung involvement
☐ Other: _____

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** **Lab requirements: serum total IgE level (IU/mL) measured before the start of treatment as well as patient body weight*	☐ 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

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.***