AOM Infusion
Improving Health, Enhancing Life

Dermatology 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
- ☐ Labs
- ☐ Medication List
- ☐ Clinicals showing infusion need: progress notes, treatment HX, diagnostic labs or biopsy results
- ☐ Additional Information: _____

Patient Diagnosis, ICD-10 Codes:
- ☐ L10.0 Pemphigus vulgaris
- ☐ L10.2 Pemphigus foliaceus
- ☐ L10.81 Paraneoplastic pemphigus
- ☐ L12.0 Bullous pemphigoid
- ☐ L12.1 Cicatricial (mucous membrane) pemphigoid
- ☐ L40.0 Psoriasis vulgaris
- ☐ L73.2 Hidradenitis suppurativa (HS)
- ☐ L95.x Cutaneous vasculitis
- ☐ M33.x Dermatomyositis/Polymyositis
- ☐ Other: _____

Prescription Information

☐ **Immunoglobulin**	Administration route (select one): ☐ IV Infusion (IVIG) ☐ Subcutaneous infusion (SCIG)	Loading Dose: _____ gm/kg over _____ days Maintenance: _____ gm/kg over _____ days every _____ week(s)
☐ **Infliximab product:** Avsola, Inflectra, Remicade, Renflexis, unbranded Infliximab	Induction Dose: infuse _____ mg/kg IV on weeks 0, 2, and 6 Maintenance Dose: Infuse _____ mg/kg IV every _____ weeks	☐ Rapid infusion: may infuse subsequent doses over one hour based on patient tolerability
☐ **Cimzia**	Initial dosing: 400mg SQ at week 0, 2, and 4 Maintenance: 400mg SQ every other week	For patients ≤90 kg, 200mg SQ every other week may be considered
☐ **Rituxan or other Biosimilar product:** Rituxan, Ruxience, Truxima, Riabni	Dosing: Infuse _____ mg IV at week 0 and week _____ *(leave blank if only one dose)*, then repeat cycle every _____ weeks *(usually months not weeks but after clinical evaluation)*	
☐ **Tremfya**	Dosing: 100mg SQ at weeks 0, 4, and then every 8 weeks	

☐ **Stelara or biosimilar product:** Stelara, Steqeyma,Yesintek, Imuldosa, Selarsdi, Pyzchiva, or other

Adult:
- ☐ ≤100kg: 45mg SQ at week 0 and 4, then 45mg every ____ weeks
- ☐ >100kg: 90mg SQ at 0 and 4 weeks, then 90mg every ____ weeks

Pediatric:
- ☐ <60kg: 0.75mg/kg SQ at 0 and 4 weeks, followed by every 12 weeks
- ☐ 60-100kg: 45mg SQ at 0 and 4 weeks, followed by every 12 weeks
- ☐ >100kg: 90mg SQ at 0 and 4 weeks, followed by every 12 weeks

☐ **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, approximately 30 minutes prior to each infusion.

☐ Acetaminophen PO_____mg tablet, approximately 30 minutes prior to each infusion.

☐ Methylprednisolone IV_____mg, approximately 30 minutes prior to each infusion.

☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____

☐ Other _____ ☐ PO or ☐ IV, Strength _____ Directions _____

☐ None

☐ NS 500ML bolus _____ Other _____ (in case 250 pre and 250 post) ☐ Pre-hydration ☐ Post hydration ☐ Pre and post hydration

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.

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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.***

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