AOM Infusion
Improving Health, Enhancing Life

Immunoglobulin (IVIG & SCIG) Infusion Referral Form

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
- ☐ Labs
- ☐ Clinicals showing infusion need: i.e. progress notes, diagnostic labs/scans/ biopsy, tried and failed medication HX
- ☐ Additional Information _____

Patient Diagnosis, ICD-10 Codes:
- ☐ D69.3 Immune Thrombocytopenic Purpura (ITP)
- ☐ D80.1 Nonfamilial hypogammaglobulinemia
- ☐ D80.3 Selective deficiency of immunoglobulin G, subclass deficiency
- ☐ D80.6 Antibody deficiency with near-normal immunoglobulins or hyperimmunoglobulinemia
- ☐ D83.9 Common Variable Immune Deficiency (CVID)
- ☐ G35.A Relapsing-remitting multiple sclerosis (RRMS)
- ☐ G61.0 Guillan-Barre syndrome
- ☐ G61.81 Chronic inflammatory demyelinating polyneuropathy (CIDP)
- ☐ G61.82 Multifocal motor neuropathy (MMN)
- ☐ G70.00 Myasthenia gravis without acute exacerbation
- ☐ G70.01 Myasthenia gravis with acute exacerbation
- ☐ M30.3 Kawasaki disease
- ☐ M33.x Dermatomyositis/polymyositis
- ☐ Other: _____

Prescription Information

☐ **Immunoglobulin**

Administration route (select one): ☐ IV Infusion (IVIG) ☐ Subcutaneous infusion (SCIG)
☐ Dosing: _____ gm/kg over _____ days, every _____ weeks ☐ Pharmacy to dose

☐ **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. ☐ 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 _____

☐ 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: _____

Substitutions permitted unless "No Substitution" is noted on this form.

Date: _____

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.***