MIC | METRO INFUSION CENTER

INFUSION ORDERS- AVSOLA (INFLIXIMAB-axxq)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE	
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ Other: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, HBsAb, w/ reflex HB Core w/IgG and IgM	☐ TB Test Results
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	☐ Avsola 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	☐ Avsola 5mg/kg IV every 8 weeks
Alternative Dosing	☐ Avsola _____ IV every _____ weeks
Patient Weight= _____ kg	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PREMEDICATIONS
☐ Acetaminophen 650mg PO prior to Avsola infusion
☐ Diphenhydramine 25mg PO prior to Avsola infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other:

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 06/12/24