



INFUSION ORDERS- AVSOLA (INFLIXIMAB-axxq)

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

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

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

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

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

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO prior to Avsola infusion
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Avsola infusion
<input type="checkbox"/> Methylprednisolone 40mg Slow IV Push PRN infusion reaction
<input type="checkbox"/> 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.