Avsola Order Form
(infliximab-axxq)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

DERMATOLOGY
- ☐ L40.5_____ Psoriatic Arthritis/Arthropathy
- ☐ L40._____ Psoriasis

GASTROENTEROLOGY
- ☐ K50.0_____ Crohn's Disease, Small Intestine
- ☐ K50.1_____ Crohn's Disease, Large Intestine
- ☐ K50.8_____ Crohn's Disease, Small & Large Intestine
- ☐ K50.9_____ Crohn's Disease, Unspecified
- ☐ K51.8_____ Other Ulcerative Colitis, Chronic
- ☐ K51.5_____ Left Sided - Ulcerative Colitis, Chronic
- ☐ K51.0_____ Universal Ulcerative Pancolitis, Chronic
- ☐ K51.9_____ Ulcerative Colitis, Unspecified
- ☐ K60.3 Anal Fistula
- ☐ K63.2 Fistula of Intestine

RHEUMATOLOGY
- ☐ M05._____ Rheumatoid Arthritis, w/ Rheumatoid Factor
- ☐ M06._____ Rheumatoid Arthritis, w/o Rheumatoid Factor
- ☐ L40.5_____ Psoriatic Arthritis/Arthropathy
- ☐ M45._____ Ankylosing Spondylitis
- ☐ D86.0 Sarcoidosis of the Lung

OTHER: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative Hepatitis B within 3 years and Negative TB within 12 months.**

PRESCRIPTION

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP
- ☐ Famotidine: 20 mg PO
- ☐ Methylprednisolone: 125 mg SIVP

Other: _____

Lab Orders+
Required: Negative TB, annually

+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Avsola (infliximab-axxq)

Infuse in 250 mL of 0.9% NS over at least 2 hours via pump with 0.2-micron filter. Doses > 1000 mg need total volume of 500 mL.

Loading Dose: **(SELECT ONE)**
- ☐ **IV:** Infuse 3 mg/kg at weeks 0, 2, and 6
- ☐ **IV:** Infuse 5 mg/kg at weeks 0, 2, and 6
- ☐ **IV:** Infuse _____ mg or _____ mg/kg at weeks 0, 2, and 6

Maintenance: **(SELECT ONE)**
- ☐ **IV:** Infuse 3 mg/kg every 8 weeks for one year
- ☐ **IV:** Infuse 5 mg/kg every 8 weeks for one year
- ☐ **IV:** Infuse _____ mg or _____ mg/kg every _____ weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____