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ThrIVewell INFUSION
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REJUVEINATE

# INFUSION ORDERS
# AVSOLA (INFLIXIMAB-axxq)

**Date:** _____

## PATIENT INFORMATION

| | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

## REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal ☐ Discontinuation Order

## 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 | ☐ Every 6 weeks |
| Patient Weight= _____ kg | | ☐ Every 8 weeks |
| Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses | | ☐ Other |

## 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: |

## ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____