

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



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

<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 <input type="checkbox"/> Every 6 weeks
Patient Weight= _____ kg	<input type="checkbox"/> Every 8 weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses <input type="checkbox"/> 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: _____

PRESCRIBER INFORMATION

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

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____