

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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: _____

PRESCRIBER INFORMATION

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

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____