Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 ____________