

Avsola



(Or other Infliximab products such as Inflectra, Remicade, or Renflexis as required by the patient's health plan.)

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, Recent TB & Hep B Results

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): K50.____ K51.____ M06.00 ICD Description:
 M05.60 M05.70 M45.9 L40.50 L40.0

Allergies: Weight (lbs/kg): Height:

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- TB Results (list results/date & attach clinicals):

- Hepatitis B Status & Date (list results & attach clinicals):

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

- Diphenhydramine 25mg / 50mg PO / IV
- Acetaminophen 325mg / 500mg / 650mg PO
- Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

- Infliximab Intravenous Infusion
Dose:
Weight Based: 3mg/kg 5mg/kg 7.5mg/kg 10mg/kg
OR Total dose = _____ mg
 Other: _____
 Round UP to the nearest 100mg vial OR Give exact dose
 Rapid infusion (over one hour) starting after first maintenance infusion
Frequency:
 Induction: Week 0, 2, and 6
 Maintenance: Every 4 weeks / 6 weeks / 8 weeks
 Other: _____
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) Provider Signature Date

- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.