

**Avsola® (infliximab-axxq) Order Form**

**Please include the following (required):**

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B vaccine or testing documentation.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Height**

\_\_\_\_\_  
**Weight**

\_\_\_\_\_  
**Allergies**

\_\_\_\_\_  
**Patient Phone**

**Diagnosis (must include ICD-10 code)**

- Rheumatoid Arthritis \_\_\_\_\_  Psoriatic Arthropathy \_\_\_\_\_  
 Psoriasis \_\_\_\_\_  Ankylosing Spondylitis \_\_\_\_\_  
 Crohn's Disease \_\_\_\_\_  Ulcerative Colitis \_\_\_\_\_  
 Other (ICD-10 Code): \_\_\_\_\_

**Prescription Orders: Avsola® (infliximab-axxq) (quantity: 100 mg per vial)**

**\*\*0.2-micron filter must be used during infusion\*\***

- Initial Dosing: \_\_\_\_\_ mg/kg IV on day 0, 2 weeks, 6 weeks, and then every \_\_\_\_\_ weeks.  
 Renewal Dosing: \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks. (date of last infusion \_\_\_\_\_)

**Pre-Medications:**

- Acetaminophen 650mg PO     Benadryl 25 mg IVP     Solu-Medrol 40mg IVP  
 Benadryl 50 mg IVP     Solu-Medrol 125 mg IVP  
 Other \_\_\_\_\_

**Standing Lab Orders:**  CMP  CBC  ESR  CRP  Other: \_\_\_\_\_  
 every infusion     every other infusion

**Refills:**  12 months or  for \_\_\_\_\_ infusions

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Fax**

\_\_\_\_\_  
**Provider's signature**

\_\_\_\_\_  
**Date**

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.**

**For any other questions please call (469) 480-9649.**

**Or visit us online at [www.ntinfusioncenters.com](http://www.ntinfusioncenters.com)**