Avsola
(infliximab-axxq)

Infusion order

249 Danbury Rd, Wilton, CT 06897
400 Columbus Ave, Valhalla, NY 10595
127 Washington Ave, N. Haven, CT 06473
220 Farmington Ave, Farmington, CT 06032
Ph: 203-883-0038 Fax: 203-724-4838

Patient Name: ____________________________ DOB: _____/_____/_______ M ◯ F ◯

Allergies: ________________________________ Phone: ____________________

Diagnosis: ________________________________ ICD- 10: __________________________________

Please fax a copy of the following patient information:

☐ Recent progress Note ☐ Current CBC & CMP ☐ TB & Hep B Results *(upon initiation)*

TB test date: _____/_____/_______ Result: __________ *(can be PPD skin test or QuantiFERON TB gold blood test)*

Hep B (HBsAg and anti- HBV) test date: _____/______/_______ Result: __________

PRE- MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ No Pre-med

☐ Solu- Medrol 125mg IVP
☐ Solu- Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
Other: _________________________________

AVSOLA ORDERS / IV DOSAGE

◯ ____________ mg/kg *weight-based* Patient Weight: ___________ lbs / kg

◯ ____________ mg *flat-dosed* Height: _______ft_______in

FREQUENCY

◯ at weeks 0, 2 and 6, then every 8 weeks *(initial)* ***OR*** ◯ *every* _________ *weeks (continuation)*

NOTES:

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Provider's Name: ________________________________ Signature**:** ______________________________________

NPI: _________________ Date: ____________________ Ph: __________________ Fax: __________________