Infliximab (Avsola)

Provider Order Form rev. 11/23/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 Code

- ☐ K51.90 Adult Ulcerative Colitis
- ☐ K50.90 Adult Crohn's Disease
- ☐ M05.79 Rheumatiod arthritis with rheaumatiod factor of multiple sites without organ or systems involvement
- ☐ M06.09 Rheumatiod arthritis without rheaumatiod factor of multiple sites
- ☐ M06.9 Rheumatiod arthritis, unspecified
- ☐ Other: _____

MEDICATION ORDER

NOTE: Many payors require patients start therapy with an infliximab biosimilar.

- ☐ Infuse infliximab (Remicade) OR infliximab biosimilar as required by patient's insurance.
- ☐ Infuse the preferred product (subject to prior authorization):
  - ☐ infliximab (Remicade) ☐ infliximab-axxq (Avsola)
  - ☐ infliximab-dyyb (Inflectra) ☐ infliximab-abda (Renflexis)
- ☑ Mix in 250ml 0.9% sodium chloride, intravenous infusion over two hours (use in line filter 1.2 micron or less)
  - Dose: ☐ 3mg/kg ☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ Other: _____ ☐ Round up to nearest 100mg **OR** ☐ Give exact dose
  - Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks / ☐ maintenance: every 8 weeks / ☐ other: _____
  - Infusion rate: 10ml/hr x 15 min
    - Increase to: 20ml/hr x 15 min, 40ml/hr x 15 min, 80ml/hr x 15 min, 150ml/hr x 30 min, 250ml/hr until infusion complete
  - ☑ Flush with 0.9% sodium chloride at infusion completion
- ☐ Patient is required to stay for 30-minute observation post infusion
- ☐ Patient is NOT required to stay for observation time
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes)
- ☐ Current Medication
- ☐ History and Physical Report
- ☐ Lab Results
- ☐ Insurance Cards (front and back)
- ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ ANA (SLE)
- ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months