AVSOLA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ DEA: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

City, State, Zip: _____

Plan #: _____

Group #: _____

Phone: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

City, State, Zip: _____

Group #: _____

Phone: _____

CLINICAL INFORMATION

☐ K51.90 Moderate to Severe Ulcerative Colitis
☐ K50.90 Moderate to Severe Crohn's Disease
☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ L40.52 Psoriatic Arthritis
☐ L40.0 Plaque Psoriasis
☐ Other: _____

*If PPD test results are not within 12 months, please perform PPD.

Tuberculosis Screening: ☐ PPD Test Date: _____-_____-_____

Results: ☐ Negative

☐ Positive → ☐ Chest X-Ray Performed Date: ____-_____-_____

X-Ray Results: ☐ Negative

☐ Positive → TB treatment Initiated

Labs:

☐ CBC q: _____ ☐ CMP q: _____ ☐ CRP q: _____ ☐ ESR q:_____ ☐ LFTs q: _____ ☐ X-Ray: _____ ☐ Other: _____

**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

AVSOLA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion: _____

Medication	Directions	Quantity/Refills
Avsola® (infliximab-axxq)	**Loading dose:** ☐ 5mg/kg _____ mg IV at week: 0, 2, 6 ☐ 3mg/kg _____ mg IV at week: 0, 2, 6 ☐ Other: _____ ☐ **Maintenance dose:** (_____ mg/kg) _____ mg IV every _____ weeks	**Loading dose:** 3 doses. No refills. **Maintenance dose:** 8-week supply. Refill x 1 year unless noted otherwise. ☐ _____ week supply Refill x 1 year unless noted otherwise. ☐ Other: _____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

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☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

☐ Other: _____

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.