Avsola (infliximab-axxq)

☐ New Referral ☐ Continuing Treatment ☐ Medication Order Change

Patient Information:

Name:_____
Date:_____
DOB:_____
SS#:_____
Phone #:_____
Email:_____

Physician Information:

Referring Physician: _____

Address:_____
_____

Phone #:_____

Fax #:_____

Medication Orders

Patient Weight: _____kg Patient Height: _____inches ☐ First Dose ☐ Maintenance Dose

Dosing: ☐ **LOADING DOSES: _____MG/KG IV @ 0 weeks, 2 weeks, 6 weeks, and then every 8 weeks**

☐ **_____MG/KG IV every _____ weeks**

Premeds(if applicable): ☐ _____ ☐ _____ ☐ _____ ☐ _____

Indication / Diagnosis:

- ☐ M05.____ Rheumatoid arthritis
- ☐ M06.____ Rheumatoid arthritis, unspecified
- ☐ L40._____ Psoriatic arthritis
- ☐ L40.0 Plaque psoriasis
- ☐ M45.____ Ankylosing spondylitis
- ☐ K50._____ Crohn's disease
- ☐ K51._____ Ulcerative Colitis
- ☐ Other (please specify)_____

ICD-10 (Required) _____

MD Sianature: **NPI#:** **Date:**

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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