

Avsola Order

(Infliximab)



InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** Demographics Insurance Information Current CBC & CMP
 H & P Relevant to Diagnosis Current Medications TB & Hep B Results
 Colonoscopy/Pathology (GI only)

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

TB Test Date: _____ Result: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Hep B Date: _____ Result: _____

PRE-MEDICATIONS:

Benadryl: PO IV 25mg 50mg Pre-med PRN

Acetaminophen: 325mg 650mg Pre-med PRN

Zyrtec 10mg Pre-med PRN

Solu-Medrol: IV _____ mg Pre-med PRN

Dexamethasone: IV 10mg 5mg Pre-med PRN

AVSOLA (INFLIXIMAB) IV DOSING

Date of Last Treatment, If Continuation: _____

3 mg/kg 5 mg/kg 7.5 mg/kg 10 mg/kg

Round to nearest vial (100 mg per vial) **OR** Total dose = _____ mg
 Weight based dosing per visit (Pediatric)

Frequency: Initial dose at 0, 2, 6 weeks, **then** Q 4 weeks Q 6 weeks Q 8 weeks

Next dose due: _____