Avsola Order
(Infliximab)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Current Medications ☐ TB & Hep B Results

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: _____

Hep B Date: ___/___/___ Result: _____

PRE-MEDICATIONS:

Benadryl:	☐ PO	☐ IV	☐ 25mg	☐ 50mg	☐ Pre-med	☐ PRN
Acetaminophen:	☐ PO		☐ 325mg	☐ 650mg	☐ Pre-med	☐ PRN
☐ Claritin or ☐ Zyrtec	☐ PO		☐ 10mg		☐ Pre-med	☐ PRN
Solu-Medrol:		☐ IV	☐ _____ mg		☐ Pre-med	☐ PRN
Normal Saline Bolus:		☐ IV	☐ 250mL		☐ Pre-med	☐ PRN
Zofran:	☐ PO	☐ IV	☐ _____ mg		☐ Pre-med	☐ PRN

AVSOLA (INFLIXIMAB) IV DOSING

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

☐ Round to nearest vial (100 mg per vial)
☐ Pediatric; weight based dosing per visit

OR ☐ Total dose = _____ mg

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

Next dose due: ___/___/___

Revised 03/05/21