Phone and Fax: 608-690-7210
www.MySmartInfusion.com

Avsola (Infliximab-axxq)
Infusion Order Form

Patient Information

Patient Name: ____DOB: _____________________ M ☐ F ☐

Allergies: ____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____________ Next Due Date: _____________

Diagnosis and ICD 10 Code (Required)

☐ Moderate to Severe Ulcerative Colitis ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease ICD 10 Code: K50.90
☐ Rheumatoid Arthritis ICD 10 Code: M06.9
☐ Ankylosing Spondylitis ICD 10 Code: M45.9
☐ Psoriatic Arthritis ICD 10 Code: L40.52
☐ Plaque Psoriasis ICD 10 Code: L40.0

Required Labs

TB/QuantiFERON (within 12 months & attach results)
Hepatitis B Status & Date: ______________________________
Most recent CBC & CMP (attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: __________________________ Route: _____________
Dose: ______________ Frequency: ______________________

Nursing

Provide nursing care per Smart Infusion Nursing Procedures,
Including reaction management and post-procedure observation.

Special Instructions / Notes

Avsola Medication Orders

Patient Weight: ______________ KG

Dosage
☐ 3mg/kg IV ☐ 5mg/kg IV ☐ 10mg/kg IV
☐ ___________mg/kg
We will round to the nearest full vial unless checked no ☐

Frequency
☐ Induction week 0, 2, 6 then every 8 weeks
☐ Maintenance every 8 weeks
☐ Other ____

Required Documents
☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Location
☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: ____ Provider NPI: __________________________

Office Phone: ____ Office Fax: ____

Provider Signature: ____ Date: _______________________