FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

INFUSION ORDERS
AVSOLA (NFLIXIMAB-axxq)

☐ _____ ok the switch to biosimilar if insurance formulary prefers

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE

☐ 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
☐ Other: _____	ICD10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	Clinical/Progress notes
☐ Patient demographics AND insurance information	Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, HBsAb, w/ reflex HB Core w/IgG and IgM	TB Test Results

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS

Initial Dosing	☐ Avsola 5mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter
Maintenance Dosing	☐ Avsola 5mg/kg IV every 8 weeks
Alternative Dosing	☐ Avsola _____ IV every _____ weeks

Patient Weight= _____ kg

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS

☐ Acetaminophen 650mg IV prior to Avsola infusion
☐ Diphenhydramine 25mg IV prior to Avsola infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other:

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCRIBER INFORMATION

Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____