

Avsola® | (Infliximab-axxq)

Please fax a copy of the following patient information:



Demographics Insurance information Current Lab Results H&P Current Medication

Patient Information



Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs/kg Height: _____

Diagnosis/ ICD-10:

- Crohn's disease, unspecified / K50.9
- Ulcerative colitis, unspecified / K51.9
- Rheumatoid arthritis, unspecified / M06.9
- Rheumatoid arthritis without rheumatoid factor / M06.00
- Rheumatoid arthritis with rheumatoid factor, unspecified / M05.9
- Other (please specify) _____

Additional information: _____

Provider Information



Printed Provider's Name: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Medication Information



Dose: _____ Frequency and Duration: _____

Start Date of Infusion: _____ End Date of Infusion: _____

Other Orders or Special Instructions: _____

