AYSA
THERAPEUTICS INFUSION

INFLIXIMAB ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ______________ Phone: ______________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis:
☐ Rheumatoid Arthritis (____________) ☐ Ankylosing Spondylitis (___________)
☐ Crohn's Disease (___________) ☐ Ulcerative Colitis (___________)
☐ Psoriasis (___________) ☐ Other: ________________(___________)

Patient Weight: ____________ lbs. **Allergies:** ______________________________________

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ TB test, Hepatitis B antigen, Hepatitis B core total antibody attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ______________________________________ ☐ Perform yearly TB test *(optional)*

REMICADE ORDERS

J1745
Remicade Dose: __________ mg/kg **Frequency:** Every: ___________ weeks or ☐ 0, 2, 6, then every 8 weeks

RENFLEXIS ORDERS

Q5104
Renflexis Dose: __________ mg/kg **Frequency:** Every: ___________ weeks or ☐ 0, 2, 6, then every 8 weeks

INFLECTRA ORDERS

Q5103
Inflectra Dose: __________ mg/kg **Frequency:** Every: ___________ weeks or ☐ 0, 2, 6, then every 8 weeks

AVSOLA ORDERS

Q5121
Avsola Dose: __________ mg/kg **Frequency:** Every: ___________ weeks or ☐ 0, 2, 6, then every 8 weeks

PRE-MEDICATION ORDERS

Protocol Pre-Medication Orders: Tylenol 1000mg PO, *please choose one antihistamine*

☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol ________ mg IV ☐ Solu-Cortef ________ mg IV

☐ Other: ______________________________________

Additional Orders/ Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*., and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________ Physician Name: ______________________ Date: __________
Phone: ____________________ Fax: ____________________ Contact Person: ______________________

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