TNF ORDER

FAX: 800-987-6552
Phone: 877-283-8679

PATIENT INFORMATION

Patient Name:	Ship to: ☐ Home ☐ Office		DOB:	
Home Address:	City:		State:	Zip:
Home Phone:	Height:	Weight:	Gender: ☐ Male ☐ Female	
Cell Phone:	Email Address:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy#:	Group#:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION (fax all pertinent clinical and lab information)

Diagnosis (ICD-10):	Date of Diagnosis:	List of Failed Therapies:		
Has patient completed induction/loading doses? ☐ Yes ☐ No	Date of last infusion:	Date of next infusion:	Access:PIV ☐ PICC ☐ PORT ☐	
Negative TB Test: ☐ Yes ☐ No	Previously vaccinated against Hepatitis B or Negative HBsAg? ☐ Yes ☐ No	Recent liver function tests on file: ☐ Yes ☐ No		
List additional comorbidities:	Allergies:			

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

TNF - Inhibitor Brand ☐ **Remicade (infliximab)** ☐ **Inflectra (infliximab)** ☐ **Renflexis (infliximab)** ☐ **Simponi Aria (golumumab)**

Induction/Loading Doses	**Induction Dose Week #**	**Dose**	**Date received, if previously administered**
	Week # _____	_____ mg OR _____ mg/kg	
	Week # _____	_____ mg OR _____ mg/kg	
	Week # _____	_____ mg OR _____ mg/kg	

Maintenance Dose

Dose: _____ mg OR _____ mg/kg IV once every _____ weeks per manufacturer's guidelines, as tolerated.

**Pharmacy will round up to nearest vial size for weight-based dosing.*

**May adjust infusion schedule +/- 7 days to accommodate nurse and patient scheduling.*

Pre-Medications and Flushing Protocol	**Pre-Medications:** administered 30 minutes prior to infusion.	**IV Flushing Protocol:**
	☐ Diphenhydramine _____mg ☐ PO or ☐ IV	☐ Sodium Chloride 0.9% 5-10 mL pre and post medication and prn
	☐ Acetaminophen _____ mg PO	☐ Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn
	☐ Solu-Medrol _____ mg IV OR ☐ Solu-Cortef _____ mg IV	☐ Heparin 100 u/ml Central Line: 5ml after last NaCl 0.9% flush and prn

Refill: ☐ **PRN x 1 year (OR _____ times) *The quantity and refills for all ancillary medications will match the TNF Inhibitor administration requirements.**

Anaphylaxis Orders and Medications	☐ Provide anaphylaxis kit per pharmacy protocol.
Pump and Ancillary Supplies	☐ Provide pump and supplies as needed for dilution, administration, and appropriate disposal of infusion materials.
Skilled Nursing Orders and Plan of Treatment	☐ Provide skilled nursing for home infusion.
	☐ In-office infusion; no nursing needed.

Administration procedures to be followed per pharmacy protocol or manufacturer's guidelines.

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email Address:	
Address:		
NPI:		

Prescriber Signature: Date:

Your signature authorizes AvevoRx, LLC and their network of pharmacies, Mid-Valley Health System (the "AvevoRx Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.