



# TNF ORDER

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

## PATIENT INFORMATION

Patient Name:	Ship to: <input type="checkbox"/> Home <input type="checkbox"/> Office	DOB:
Home Address:	City:	State: <input type="text"/> Zip: <input type="text"/>
Home Phone:	Height:	Weight: <input type="text"/> Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last infusion:	Date of next infusion:
Negative TB Test: <input type="checkbox"/> Yes <input type="checkbox"/> No	Previously vaccinated against Hepatitis B or Negative HBsAg? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent liver function tests on file: <input type="checkbox"/> Yes <input type="checkbox"/> No
List additional comorbidities:	Allergies:	

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

<b>TNF - Inhibitor Brand</b>	<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Inflectra (infliximab) <input type="checkbox"/> Renflexis (infliximab) <input type="checkbox"/> Simponi Aria (golumumab)		
<b>Induction/Loading Doses</b>	<b>Induction Dose Week #</b>	<b>Dose</b>	<b>Date received, if previously administered</b>
	Week # _____	_____ mg OR _____ mg/kg	
	Week # _____	_____ mg OR _____ mg/kg	
	Week # _____	_____ mg OR _____ mg/kg	
<b>Maintenance Dose</b>	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.		
<b>Pre-Medications and Flushing Protocol</b>	<b>Pre-Medications:</b> administered 30 minutes prior to infusion.	<b>IV Flushing Protocol:</b>	
	<input type="checkbox"/> Diphenhydramine _____ mg <input type="checkbox"/> PO or <input type="checkbox"/> IV	<input type="checkbox"/> Sodium Chloride 0.9% 5-10 mL pre and post medication and prn	
	<input type="checkbox"/> Acetaminophen _____ mg PO	<input type="checkbox"/> Heparin 10 u/ml Peripheral Line: 3 ml after last NaCl 0.9% flush and prn	
	<input type="checkbox"/> Solu-Medrol _____ mg IV OR <input type="checkbox"/> Solu-Cortef _____ mg IV	<input type="checkbox"/> Heparin 100 u/ml Central Line: 5ml after last NaCl 0.9% flush and prn	
<b>Refill:</b> <input type="checkbox"/> PRN x 1 year (OR _____ times) *The quantity and refills for all ancillary medications will match the TNF Inhibitor administration requirements.			

<b>Anaphylaxis Orders and Medications</b>	<input type="checkbox"/> Provide anaphylaxis kit per pharmacy protocol.
<b>Pump and Ancillary Supplies</b>	<input type="checkbox"/> Provide pump and supplies as needed for dilution, administration, and appropriate disposal of infusion materials.
<b>Skilled Nursing Orders and Plan of Treatment</b>	<input type="checkbox"/> Provide skilled nursing for home infusion.
	<input type="checkbox"/> 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.	

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