

**Patient Information**

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

**Additional Information Needed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs                 |
| <input type="checkbox"/> Fax patient demographics         | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

**Diagnosis and Clinical Information**
**Diagnosis (ICD-10):**

- M05.79 Rheumatoid Arthritis with Rheumatoid Factor of Multiple Sites without Organ or Systems Involvement  
 M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified  
 M06.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites  
 M06.9 Rheumatoid Arthritis, Unspecified  
 M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site  
 M08.20 Juvenile Rheumatoid Arthritis with Systemic Onset, Unspecified Site  
 M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica  
 Other: Code: \_\_\_\_\_ Description: \_\_\_\_\_

**Clinical Information:**

- New Therapy Induction     Therapy Change     Therapy Continuation  
 Patient Weight: \_\_\_\_\_ lbs / \_\_\_\_\_ kg     Patient Height: \_\_\_\_\_ in / \_\_\_\_\_ cm  
 Allergies: \_\_\_\_\_  
 Therapies Tried and Failed: \_\_\_\_\_  
 TB Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_     Hep B Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_

**Lab Orders**

- CBC     CMP     ESR     CRP     HBsAg     HBsAB     HBcAB     Quantiferon Gold  
 Other: \_\_\_\_\_

**Lab Orders to be done by**

- Oklahoma Infusion Services  
 Referring Provider

**Prescription Information**

- |                                  |  |   |
|----------------------------------|--|---|
| <input type="checkbox"/> Actemra | <input type="checkbox"/> Dose: 4mg/kg      | <input type="checkbox"/> Frequency: every 2 weeks                 |
|                                  | <input type="checkbox"/> Dose: 8mg/kg      | <input type="checkbox"/> Frequency: every 4 weeks                 |
|                                  | <input type="checkbox"/> Dose: _____ mg/kg | <input type="checkbox"/> Frequency: _____ mg/kg every _____ weeks |

**Pre-Medication Orders**

- Solu-Cortef 50-100mg SIVP     Benadryl 25mg PO PRN  
 Tylenol tablet 500-1000mg PO PRN     Other: \_\_\_\_\_

**Standing Orders for Adverse Reactions**

- |   |  |
|---|--|
| <input type="checkbox"/> Stop infusion and initiate NS bolus                    | <input type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis    |
| <input type="checkbox"/> Notify supervising physician and ordering provider     | <input type="checkbox"/> Oxygen 2-5L nasal cannula                       |
| <input type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction       | <input type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____                                    |

**Prescriber Information**


Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:


Prescriber's Signature: \_\_\_\_\_


Date: \_\_\_\_\_

*By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.*

Please fax form to: 405-726-9849

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**Phone:** (580) 701-2586

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**Phone:** (539) 215-5609