

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):

- M32.10 Systemic Lupus Erythematosus, Organ or System Involvement Unspecified
 M32.8 Other Forms of Systemic Lupus Erythematosus
 M32.9 Systemic Lupus Erythematosus, Unspecified
 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

- Benlysta Initial Dose: 10mg/kg weeks 0, 2, 4
 Maintenance Dose: 10mg/kg every 4 weeks after week 4
 Maintenance Dose: _____ mg/kg every _____ weeks after week 4

Pre-Medication Orders

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

Standing Orders for Adverse Reactions

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

 **Edmond**
 1701 Renaissance Blvd, Ste 110
 Edmond, OK 73013
Phone: (405) 844-4978

 **Enid**
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