

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):

- | | |
|--|--|
| <input type="checkbox"/> M17.0 Bilateral Primary OA of Knee | <input type="checkbox"/> M17.4 Other Bilateral Secondary OA of Knee |
| <input type="checkbox"/> M17.11 Unilateral Primary OA, Right Knee | <input type="checkbox"/> M17.5 Other Unilateral Secondary OA of Knee |
| <input type="checkbox"/> M17.2 Bilateral Post-Traumatic OA of Knee | <input type="checkbox"/> M17.9 OA of Knee, Unspecified |
| <input type="checkbox"/> Other: Code: _____ Description: _____ | |

Clinical Information:

- | | | |
|---|--|---|
| <input type="checkbox"/> New Therapy Induction | <input type="checkbox"/> Therapy Change | <input type="checkbox"/> Therapy Continuation |
| <input type="checkbox"/> Patient Weight: _____ lbs / _____ kg | <input type="checkbox"/> Patient Height: _____ in / _____ cm | |
| <input type="checkbox"/> Allergies: _____ | | |
| <input type="checkbox"/> Therapies Tried and Failed: _____ | | |

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"/> Durolane | <input type="checkbox"/> Dose: 60mg/3mL Prefilled Syringe | <input type="checkbox"/> Frequency: intra-articularly one time |
| | <input type="checkbox"/> Directions: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other Joint: _____ | |
| <input type="checkbox"/> Gelsyn-3 | <input type="checkbox"/> Dose: 16.8mg/2mL Prefilled Syringe | <input type="checkbox"/> Frequency: intra-articularly every week for 3 weeks |
| | <input type="checkbox"/> Directions: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other Joint: _____ | |
| <input type="checkbox"/> Supartz FX | <input type="checkbox"/> Dose: 25mg/2.5mL Prefilled Syringe | <input type="checkbox"/> Frequency: intra-articularly every week for 5 weeks |
| | <input type="checkbox"/> Directions: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other Joint: _____ | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Medication: _____ <input type="checkbox"/> Dose: _____ <input type="checkbox"/> Frequency: _____ | |
| | <input type="checkbox"/> Directions: _____ | |

Pre-Medication Orders

- | | |
|--|--|
| <input checked="" type="checkbox"/> Solu-Cortef 50-100mg SIVP | <input checked="" type="checkbox"/> Benadryl 25mg PO PRN |
| <input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN | <input type="checkbox"/> Other: _____ |

Standing Orders for Adverse Reactions

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

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

Enid
 825 E Owen K Garriott Rd
 Enid, OK 73701
Phone: (580) 701-2586

Tulsa
 6135 S 90th E Ave
 Tulsa, OK 74133
Phone: (539) 215-5609