OKLAHOMA INFUSION SERVICES

Osteoarthritis Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ M17.0 Bilateral Primary OA of Knee
☐ M17.11 Unilateral Primary OA, Right Knee
☐ M17.2 Bilateral Post-Traumatic OA of Knee
☐ M17.4 Other Bilateral Secondary OA of Knee
☐ M17.5 Other Unilateral Secondary OA of Knee
☐ M17.9 OA of Knee, 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: ____

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

Medication	Orders
☐ Durolane	☐ Dose: 60mg/3mL Prefilled Syringe ☐ Frequency: intra-articularly one time ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ______________________
☐ Gelsyn-3	☐ Dose: 16.8mg/2mL Prefilled Syringe ☐ Frequency: intra-articularly every week for 3 weeks ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ______________________
☐ Supartz FX	☐ Dose: 25mg/2.5mL Prefilled Syringe ☐ Frequency: intra-articularly every week for 5 weeks ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ______________________
☐ Other	☐ Medication: ______________ ☐ Dose: ______________ ☐ Frequency: ______________________ ☐ Directions: ____

Pre-Medication Orders

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

Standing Orders for Adverse Reactions

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