

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

- | | |
|--|--|
| <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.