

**Patient Information**

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

**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):**

- M1A.00X0 Idiopathic Chronic Gout, Unspecified Site, without Tophus  
 M1A.00X1 Idiopathic Chronic Gout, Unspecified Site, with Tophus  
 M1A.09X0 Idiopathic Chronic Gout, Multiple Sites, without Tophus  
 M1A.09X1 Idiopathic Chronic Gout, Multiple Sites, with Tophus  
 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  
 HIV     G6PD     Uric Acid  
 Other: \_\_\_\_\_

**Lab Orders to be done by**

- Oklahoma Infusion Services  
 Referring Provider

**Prescription Information**

- Krystexxa     Dose: 8mg     Frequency: every 2 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**

- 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**

<b>Prescriber Name:</b>		<b>Office Contact Name:</b>	
<b>NPI #:</b>	<b>DEA #:</b>	<b>Contact Phone:</b>	<b>Contact Fax:</b>

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.*