

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):

- D57.1 Sickle-Cell Disease without Crisis
 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: _____
 Has patient experienced two or more sickle cell-related vaso-occlusive crises within the last 12 months? Yes No
 Is patient receiving concomitant chronic blood transfusion therapy? Yes No
 Is patient receiving concomitant voxelotor therapy? Yes No

Lab Orders

- CBC CMP HBsAg HBsAB HBcAB Quantiferon Gold
 Other: _____

Lab Orders to be done by

- Oklahoma Infusion Services
 Referring Provider

Prescription Information

- Adakveo Initial Dose: 5mg/kg weeks 0, 2
 Maintenance Dose: 5mg/kg every 4 weeks after week 2

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.