

Please fax form to: 405-726-9849

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"/> M80.0 Age-related Osteoporosis with Current Pathological Fracture	<input type="checkbox"/> M88.9 Paget's Disease of the Bone in Men and Women
<input type="checkbox"/> M81.0 Age-Related Osteoporosis without Current Pathological Fracture	
<input type="checkbox"/> M81.8 Other Osteoporosis without Current Pathological Fracture	
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: _____	
<input type="checkbox"/> TB Test: Date: _____ Results: _____	<input type="checkbox"/> Hep B Test: Date: _____ Results: _____
<input type="checkbox"/> Is patient currently taking Calcium/Vitamin D supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last Calcium/Vitamin D: _____	
<input type="checkbox"/> Does patient have history of fractures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Date of last DEXA scan: _____ <input type="checkbox"/> Clinical note for last DEXA scan attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Lab Orders	Lab Orders to be done by
<input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> ESR <input type="checkbox"/> CRP <input type="checkbox"/> HBsAg <input type="checkbox"/> HBsAB <input type="checkbox"/> HBcAB <input type="checkbox"/> Quantiferon Gold <input type="checkbox"/> Other: _____	<input type="checkbox"/> Oklahoma Infusion Services <input type="checkbox"/> Referring Provider

Prescription Information		
<input type="checkbox"/> Evenity	<input type="checkbox"/> Dose: 210mg (two 105mg injections)	<input type="checkbox"/> Frequency: every month for 12 months
<input type="checkbox"/> Prolia	<input type="checkbox"/> Dose: 60mg	<input type="checkbox"/> Frequency: every 6 months
<input type="checkbox"/> Zoledronic Acid	<input type="checkbox"/> Dose: 5mg	<input type="checkbox"/> Frequency: every 1 year <input type="checkbox"/> Frequency: every 2 years
<input type="checkbox"/> Other	<input type="checkbox"/> Medication: _____	<input type="checkbox"/> Dose: _____ <input type="checkbox"/> Frequency: _____

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

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