

**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):**

- K50.00 Crohn's Disease of Small Intestine without Complications  
 K50.90 Crohn's Disease, Unspecified, without Complications  
 K51.00 Ulcerative Chronic Pancolitis without Complications  
 K51.90 Ulcerative Colitis, Unspecified, without Complications  
 L40.0 Psoriasis Vulgaris (Moderate-to-Severe Plaque Psoriasis)  
 L40.50 Arthropathic Psoriasis, 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: \_\_\_\_\_  
 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"/> Stelara | <input type="checkbox"/> Initial Dose: _____ mg IV week 0  | <input type="checkbox"/> Maintenance Dose: 90mg Sub-Q every 8 weeks after week 0       |
|                                  | <input type="checkbox"/> Weight up to 55kg = 260mg <input type="checkbox"/> Weight >55kg to 85kg = 390mg <input type="checkbox"/> Weight >85kg = 520mg |  |
|                                  | <input type="checkbox"/> Initial Dose: 0.75mg/kg Sub-Q weeks 0, 4  | <input type="checkbox"/> Maintenance Dose: 0.75mg/kg Sub-Q every 12 weeks after week 4 |
|                                  | <input type="checkbox"/> Initial Dose: 45mg Sub-Q weeks 0, 4   | <input type="checkbox"/> Maintenance Dose: 45mg Sub-Q every 12 weeks after week 4      |
|                                  | <input type="checkbox"/> Initial Dose: 90mg Sub-Q weeks 0, 4   | <input type="checkbox"/> Maintenance Dose: 90mg Sub-Q every 12 weeks after week 4      |

**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.