OKLAHOMA INFUSION SERVICES

1701 Renaissance Blvd, Ste. 110
Edmond, OK 73013-5853
Phone: (405) 844-4978; Fax: (405) 844-0562

Crohn's Disease Order Form

Patient's Information

Patient's Name:	Patient's Date of Birth:	Patient's Phone:	Gender: M ☐ F ☐
Patient's Address:	Patient's Email:	Insurance:	

Additional Information

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ K50.00 Crohn's Disease of Small Intestine without Complications
☐ K50.10 Crohn's Disease of Large Intestine without Complications
☐ K50.80 Crohn's Disease of Small and Large Intestine without Complications
☐ K50.90 Crohn's Disease, Unspecified, without Complications
☐ 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

☐ Lab Orders: ☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
☐ Lab Orders to be drawn by: ☐ Oklahoma Infusion Services ☐ Referring Provider

Prescription Information

☐ Entyvio	☐ Initial Dose: 300mg weeks 0, 2, 6	☐ Maintenance Dose: 300mg every 8 weeks
☐ Remicade	☐ Initial Dose: _____ mg/kg weeks 0, 2, 6	☐ Maintenance Dose: _____ mg/kg every _____ weeks
☐ Stelara	☐ Initial Dose: ☐ Up to 55kg Dose: 260mg ☐ Greater than 55kg to 85kg Dose: 390mg ☐ Greater than 85kg Dose: 520mg ☐ Maintenance Dose: subcutaneous 90mg dose 8 weeks after Initial Dose, then every 8 weeks thereafter	
☐ Tysabri	☐ Initial Dose: 300mg	☐ Maintenance Dose: 300mg every 4 weeks
☐ Other	Medication: _____ ☐ Initial Dose: _____ mg/kg weeks _____	☐ Maintenance Dose: _____ mg/kg every _____ weeks

Pre-Medication Orders

☐ Solu-Cortef 50-100mg SIVP ☐ Benadryl 25mg PO PRN
☐ Tylenol tablet 500-1000mg PO PRN ☐ No routine premedication necessary

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's Information		Prescriber's Contact Person
Prescriber's Name:		Contact Name:
NPI #:	DEA #:	Contact Phone:
Prescriber's Signature:		Contact Fax:
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.