OKLAHOMA INFUSION SERVICES

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

Osteoarthritis 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):

☐ M17.0 Bilateral Primary OA of Knee
☐ M17.11 Unilateral Primary OA, Right Knee
☐ M17.12 Unilateral Primary OA, Left Knee
☐ M17.2 Bilateral Post-Traumatic OA of Knee
☐ M17.31 Unilateral Post-Traumatic OA, Right Knee
☐ M17.32 Unilateral Post-Traumatic OA, Left Knee
☐ M17.4 Other Bilateral Secondary OA of Knee
☐ M17.5 Other Unilateral Secondary OA of Knee
☐ M17.9 OA of Knee, 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: _____

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

☐ Durolane	Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: _____ Directions: ☐ One Time Injection ☐ Other: _____ ☐ Dose: ☐ 1 dose ☐ 2 doses ☐ Other: _____
☐ Gelsyn-3	Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: _____ Directions: ☐ Inject once weekly for 3 weeks ☐ Other: _____ ☐ Dose: ☐ 3 doses ☐ 6 doses ☐ Other: _____
☐ Supartz FX	Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: _____ Directions: ☐ Inject once weekly for: ☐ 3 weeks ☐ 4 weeks ☐ 5 weeks ☐ Other: _____ ☐ Dose: ☐ 3 doses ☐ 4 doses ☐ 5 doses ☐ 6 doses ☐ 8 doses ☐ 10 doses Other: _____
☐ Other	Medication: _____ Directions: _____ Quantity: _____

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.