

Ulcerative Colitis Order Form

Patient's Information			
Patient's Name:	Patient's Date of Birth:	Patient's Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient's Address:	Patient's Email:	Insurance:	
Additional Information			
<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"/> K51.9 Ulcerative Colitis, Unspecified			
<input type="checkbox"/> 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: _____			
Lab Orders			
<input type="checkbox"/> Lab Orders: <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"/> Lab Orders to be drawn by: <input type="checkbox"/> Oklahoma Infusion Services <input type="checkbox"/> Referring Provider			
Prescription Information			
<input type="checkbox"/> Entyvio	<input type="checkbox"/> Initial Dose: 300mg weeks 0, 2, 6	<input type="checkbox"/> Maintenance Dose: 300mg every 8 weeks	
<input type="checkbox"/> Remicade	<input type="checkbox"/> Initial Dose: _____ mg/kg weeks 0, 2, 6	<input type="checkbox"/> Maintenance Dose: _____ mg/kg every _____ weeks	
<input type="checkbox"/> Other	Medication: _____		
	<input type="checkbox"/> Initial Dose: _____ mg/kg weeks _____ <input type="checkbox"/> Maintenance Dose: _____ mg/kg every _____		
Pre-Medication Orders			
<input type="checkbox"/> Solu-Cortef 50-100mg SIVP		<input type="checkbox"/> Benadryl 25mg PO PRN	
<input type="checkbox"/> Tylenol tablet 500-1000mg PO PRN		<input type="checkbox"/> No routine premedication necessary	
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'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.