



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

OMVOH ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

K51.____ Ulcerative Colitis

K50.____ Crohn's Disease

Other _____

DOSAGE ORDERS:

Loading Doses: 300mg IV at weeks 0, 4 and 8 -UC

Maintenance: 200mg SQ (given as 2 injections of 100mg each) at week 12 then every 4 weeks -UC

Loading Doses 900mg IV at weeks 0, 4, and 8 - Crohn's

Maintenance: 300mg SQ week 12 and every 4 weeks thereafter - Crohn's

Other _____

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B
- Bilirubin
- Other: _____