PRIMERA SPECIALTY INFUSION

# OMVOH REFERRAL FORM CROHN'S DISEASE INDUCTION

**Patient Name** _____
Date of Birth _____
Gender at Birth ◯ Male ◯ Female
Address _____
City, State, Zip _____
Phone _____
Email _____
Primary Insurance _____
Secondary Insurance _____

**Prescriber Name** _____
NPI # _____ DEA # _____
State Lic # _____ UPI # _____
Practice Name _____
Address _____
City, State, Zip _____
Office Contact _____
Office Contact Phone _____
Office Contact Email _____

## CLINICAL INFORMATION

**Primary Diagnosis/ICD10** _____ **Current Therapy** _____
**Diagnosis Date** _____ **Current Directions** _____

Prior Therapies/Duration of Use _____
Access Type ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman Last Dose _____ Next Dose _____
Negative HBV ☐ Yes ☐ No Date of Test: _____ Weight _____ Height _____
Negative TB ☐ Yes ☐ No Date of Test: _____ Allergies _____

## PRESCRIPTION INFORMATION

| | |
|---|---|
| **Medication** | **OMVOH®** |
| **Directions** | Dose: **900mg** Quantity: 1 Refills: **3**<br>Directions: 900MG given as an IV infusion at Weeks 0, 2 & 8 weeks.<br>Administration Rate: ☐ Per Prescribing Information, as tolerated<br>☐ Other: _____ |
| **Pre-Medications** | ☐ Acetaminophen **650mg** 30 minutes prior to infusion PO<br>☐ Diphenhydramine **25mg** 30 minutes prior to infusion ☐ PO ☐ IV<br>☐ Solu-Cortef _____mg slow IVP<br>☐ Solu-Medrol _____mg slow IVP Administered: ☐ Pre ☐ Halfway ☐ Upon Completion |
| **Anaphylaxis Orders and Medications** | Orders:<br>1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol<br>Diphenhydramine 50mg/mL slow IVP/IM<br>Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg)<br><br>Qty 1 Epinephrine 1mg/mL– Administer___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM<br>Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr |
| **Flushing Protocol** | ☐ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin_____Units/mL _____mL as needed |
| **Pump and Ancillary Supplies** | ☐ Pump and supplies as needed for administration and appropriate disposal of infusion materials |
| **Skilled Nursing Visits** | ☐ As needed for IV access, administration and appropriate clinical monitoring |

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion. Phone (689) 303-3338 Fax (689) 303-3240 Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746

Prescriber Signature _____ Date _____