



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: 300mg Quantity: 1 Refills: 3 Directions: 300MG given as an IV infusion at Weeks 0, 2 & 8 weeks. Administration Rate: <input type="checkbox"/> Per Prescribing Information, as tolerated <input type="checkbox"/> Other: _____
Pre-Medications	<input type="checkbox"/> Acetaminophen 650mg 30 minutes prior to infusion PO <input type="checkbox"/> Diphenhydramine 25mg 30 minutes prior to infusion <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Solu-Cortef _____mg slow IVP <input type="checkbox"/> Solu-Medrol _____mg slow IVP Administered: <input type="checkbox"/> Pre <input type="checkbox"/> Halfway <input type="checkbox"/> Upon Completion
Anaphylaxis Orders and Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL- Administer ___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	<input type="checkbox"/> Sodium Chloride 0.9% 5-10mL pre and post medications <input type="checkbox"/> Heparin _____Units/mL _____mL as needed
Pump and Ancillary Supplies	<input type="checkbox"/> Pump and supplies as needed for administration and appropriate disposal of infusion materials
Skilled Nursing Visits	<input type="checkbox"/> 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 _____