



Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:  
**FAX: 410-220-2553**

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: _____		

<b>Indication:</b> <input type="checkbox"/> K51.____ Ulcerative Colitis <input type="checkbox"/> Other _____
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<b>DOSAGE ORDERS:</b> <input type="checkbox"/> Loading Doses: 300mg IV at weeks 0, 4 and 8 then <input type="checkbox"/> Maintenance: 200mg SQ (given as 2 injections of 100mg each) at week 12 then every 4 weeks <input type="checkbox"/> Other _____
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<b>PREMEDICATION ORDERS:</b> <i>not required by PI PI</i> <input type="checkbox"/> Acetaminophen po: <input type="checkbox"/> 1000mg <input type="checkbox"/> 500mg 30 min prior to infusion. <input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> 25mg PO <input type="checkbox"/> 50mg PO <input type="checkbox"/> 25mg IVP 30 min prior to infusion. <input type="checkbox"/> Solu-Medrol: <input type="checkbox"/> 62.5mg IVP <input type="checkbox"/> 100mg IVP <input type="checkbox"/> Other _____ 30 min prior to infusion. <input type="checkbox"/> Other _____
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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 Other: \_\_\_\_\_