TwelveStone Health Partners

Fax Referral To: (615) 278-3355 Direct

Phone: (844) 893-0012

Email: referral@12stonehealth.com

OMVOH ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Omvoh

Ulcerative Colitis

☐ Administer Omvoh 300mg IV over at least 30 minutes at week 0, week 4 and week 8.

☐ Administer Omvoh 200mg SQ (two injections of 100mg each) at week 12 and every 4 weeks thereafter.

Crohn's Disease

☐ Administer Omvoh 900mg IV over at least 90 minutes at week 0, week 4 and week 8.

☐ Administer Omvoh 300mg SQ (Given as two consecutive injections of 100mg and 200mg in any order) at week 12 and every 4 weeks thereafter.

Prescriber Consideration: Liver enzymes and bilirubin should be monitored for at least 24 weeks of treatment.

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Negative TB result and date: _____ ;
ALT/AST at baseline;
Bilirubin at baseline

PRE-MEDICATIONS

Oral

☐ Acetaminophen: ____ 325mg ____ 500mg ____ 650mg

☐ Loratadine: 10mg

☐ Cetirizine: 10mg

☐ Diphenhydramine: ____ 25mg ____ 50mg

☐ Famotidine: ____ 20mg ____ 40mg

☐ Ibuprofen: ____ 200mg ____ 400mg ____ 600mg

☐ Ondansetron: ____ 4mg ____ 8mg

☐ Other: _____

IV

☐ Dexamethasone: ____ 4mg ____ 8mg

☐ Diphenhydramine: ____ 25mg ____ 50mg

☐ Famotidine: ____ 20mg ____ 40mg

☐ Methylprednisolone: 125mg

☐ Hydrocortisone: 100mg

☐ Ondansetron: ____ 4mg ____ 8mg

☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date

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