TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

OMVOH™

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

ICD-10 Code (Required): _____ ICD-10 Description: _____
Baseline Liver Enzymes, Including Bilirubin (Results): _____
Date of Negative TB Test: _____ ☐ TB Test is Pending, Will Fax The Results

OMVOH™ ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Crohn's Disease Diagnosis

Induction Dosing: ☐ 3 x 300 mg/15 mL single dose vial	☐ 900 mg by intravenous infusion at Weeks 0,4, and 8	Quantity:_____
Maintenance Dosing: ☐ 1 x 100 mg/mL Prefilled Pen AND 1 x 200 mg/mL Prefilled Pen given as two consecutive subcutaneous injections ☐ 1 x 100 mg/mL Prefilled Syringe AND 1 x 200 mg/mL Prefilled Syringegiven as two consecutive subcutaneous injections	☐ 300 mg given by subcutaneous injection, given as two consecutive injections of 100 mg and 200 mg in any order, at week 12 and every 4 weeks thereafter	Quantity:_____ Refills: _____

Ulcerative Colitis Diagnosis

Induction Dosing: ☐ 300 mg / 15 mL single dose vial	☐ 300 mg by intravenous infusion at Weeks 0, 4, and 8	Quantity:_____
Maintenance Dosing: ☐ 2 x Prefilled Pen 100 mg/mL given as two consecutive subcutaneous injections ☐ 2 x Prefilled Syringe 100 mg/mL given as two consecutive subcutaneous injections	☐ 200 mg by subcutaneous injection, given as two consecutive injections of 100 mg each, at week 12 and every 4 weeks thereafter	Quantity:_____ Refills: _____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg	☐ Inject contents of 1 vial IV prior to infusion or as directed

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	☐ 125mg	☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

INFUSION REACTION ORDERS

Mild reaction protocol:

☒ Diphenhydramine 25mg IV, one time, for pruritus.

If symptoms worsen, see orders for moderate to severe reactions.

Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline: ☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	**Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:** ☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline: ☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	**PICC:** ☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	**Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:** ☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.