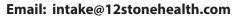
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





OMVOH ORDER FORM								
Date:		ICD-10 Code:					Therapy Status	
Patient Name:		Allergies:				☐ New Start		
Date of Birth:		Weight:Ibs	OR	kg		☐ Continuing Therapy: Last Dose:		
PROVIDER INFORMATION								
Ordering Provider: Provider Fax:								
Provider NPI:				Provider Address:				
Provider Phone:								
MEDICATION ORDER								
	Ulcerative Colitis ☐ Administer Omvoh 300mg IV over at least 30 minutes at week 4 and week 8. ☐ Administer Omvoh 200mg SQ (two injections of 100mg ea at week 12 and every 4 weeks thereafter. Crohn's Disease ☐ Administer Omvoh 900mg IV over at least 90 minutes at we week 4 and week 8. ☐ Administer Omvoh 300mg SQ (Given as two consecutive)			1)	Refills for one year fror		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: V Negative TB Quantiferon Gold	
Omvoh				eek 0, i		signature unless icated below. Refills	or TB Skin Test within the last 12 months. ✓ ALT/AST at baseline	
	injections of 100mg and 200mg in any order) at week 12 at every 4 weeks thereafter. **Prescriber Consideration: Liver enzymes and bilirubin s be monitored for at least 24 weeks of treatment.**						(within the past 60 days)✓ Bilirubin at baseline (within the past 60 days)	
PRE-MEDICATIONS								
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg								
☐ Cetirizine: 10mg				☐ Diphenhydramine:25mg50mg ☐ Famotidine:20mg40mg				
☐ Diphenhydramine:25mg50mg				☐ Methylprednisolone: 125mg				
□ Famotidine:20mg40mg				☐ Hydrocortisone: 100mg				
□ Ibuprofen: 200mg400mg600mg				☐ Ondansetron:4mg8mg				
□ Ondansetron:4mg 8mg				□ Other:				
Other:								
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION				
			,	(Please fax this signed order form, along with the following documents to 800-223-4063)				
Surveillance lab ordering and monitoring is the responsibility of the prescriber				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 informat to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.						ntions and other clinically required information		
Dispense as Written:			S	Substitution Allowed:				
Prescriber	Signature	Date	- F	Prescr	iber Sign	nature	 Date	