ADVANCED
INFUSION CENTER

OMVOH ORDER FORM

Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs./ kg

Diagnosis: check one

- o Moderate to Severe Crohn's Disease (K 50.00-K50.919), ICD 10 _____
- o Moderate to Severe Ulcerative Colitis (K51.00- K51.919, ICD 10 _____

Infusion Orders: check one

- o (Crohn's Disease) 300 mg IV at week, 0, 4, and 8
- o (Ulcerative Colitis) 900mg IV at week 0, 4, and 8

Pre-Medications Orders: check all that apply

- o Acetaminophen 650 mg po
- o Diphenhydramine 25 mg po
- o Methylprednisolone 40 mg IV

Lab Orders: _____

Required Labs to be done prior to infusion: TB test, liver enzymes and bilirubin

Additional Orders: _____

Physician Signature: _____ Date: _____

Physician Name (printed):

4362 Auburn Blvd., Sacramento, CA 95841
1215 Plumas St. Ste 1300B Yuba City, CA 95991
Ph: 916-678-5840 Fax: 916-678-5839