OMVOH
(mirikizumab-mrkz)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Baseline liver function tests (if available)

PRIMARY DIAGNOSIS

☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Omvoh
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Induction Doses (to be administered in infusion clinic):
- ☐ Omvoh 300mg IV at weeks 0, 4, and 8.

Maintenance Doses (to be self-administered by patient):
- ☐ Infusion clinic will coordinate initial maintenance dose from Specialty Pharmacy: Omvoh 200mg SubQ (given as two consecutive injections of 100mg each) at week 12 and every 4 weeks thereafter.
- ☐ Provider's office will coordinate maintenance dose from Specialty Pharmacy.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____