Omvoh

(mirikizumab-mrkz)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Ulcerative Colitis

☐ Crohn's Disease

☐ Other: _____

☐ ICD 10 Code: _____

PRESCRIPTION

Induction Dose

☐ Crohn's Disease: Omvoh 900mg IV at Weeks 0, 4, and 8

☐ Ulcerative Colitis: Omvoh 300mg IV at Weeks 0, 4, and 8

☐ Other: _____

Maintenance Doses (to be administered in an Infusion Center)

☐ Crohn's Disease: Omvoh 300mg subQ at week 12 and every 4 weeks thereafter

☐ Ulcerative Colitis: Omvoh 200mg subQ at week 12 and every 4 weeks thereafter

☐ Other: _____

Provider's office will coordinate maintenance dose from Specialty Pharmacy

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Medication List
- Tried/Failed therapies
- H&P
- Most recent labs
- Negative TB results
- Baseline LFTs (if available)

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

- Epinephrine (weight-based dosing) PRN per protocol
- Diphenhydramine PRN per protocol
- 0.9% Sodium Chloride bolus PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.