

OMVOH

(mirikizumab-mrkz)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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 FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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 FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals