

# OMVOH (MIRIKIZUMAB-MRKZ) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

Moderate to severe active ulcerative colitis, ICD 10: K51. \_\_\_\_\_

Other: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

## PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
OmvoH	<input type="checkbox"/> Initial Treatment: 300mg at Week 0, 4, and 8.	<input type="checkbox"/> IV
	Then <input type="checkbox"/> 200mg at Week 12, and every 4 weeks thereafter.	<input type="checkbox"/> SubQ

x3 IV infusions need to be completed prior to SubQ injections.

Please check this box if you **DO NOT** want Local Infusion to complete insurance portion for SubQ.

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:**  CT: 203.433.0621     ME: 207.407.7272     NH: 603.217.5371     NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_