MIRIKIZUMAB (OMVOH®) PRESCRIBER ORDER FORM

Patient Name:				**Date of Birth:**	
Address:					
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**		☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

TB Status:
- ☐ PPD (negative) – date:
- ☐ Last Chest x-ray – date:
- ☐ QuantiFERON or T Spot Assay result and date:
- ☐ Active TB
- ☐ Unknown
- ☐ Past positive TB infection, course taken:

Is this the first dose?
- ☐ Yes – date of first dose: _________________
- ☐ No – date of next dose due: _____________

Mirikizumab (Omvoh®) Prescription

Mirikizumab (Omvoh®) refill as directed x 1 year

Ulcerative Colitis

☐ Induction Dose**:** Infuse 300 mg IV over at least 30 minutes at Weeks 0, 4, and 8.
☐ Maintenance Dose: Infuse 200mg subcutaneously at week 12 and every 4 weeks thereafter (given as two consecutive injections of 100mg).
☐ Other: ____

Crohn's Disease

☐ Induction Dose**:** Infuse 900 mg IV over at least 90 minutes at Weeks 0, 4, and 8.
☐ Maintenance Dose: Infuse 300mg subcutaneously at week 12 and every 4 weeks thereafter (given as two consecutive injections of 100mg and *200mg in any order).
☐ Other: ____

*The 200mg/2mL prefilled pen and syringe are only to be used for the maintenance treatment of Crohn's Disease.

After each infusion, the IV tubing will be flushed with 0.9% Sodium Chloride 30ml using a 50ml bag.

Ancillary Orders

Anaphylaxis Kit

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses

Dosage:
- ☐ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- ☐ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- ☐ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Other: ____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Other: ____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

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

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

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