

MIRIKIZUMAB (OMVOH®) PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:	Gender:	
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:		ICD-10 Code:
TB Status:	<input type="checkbox"/> PPD (negative) – date:	<input type="checkbox"/> Active TB
	<input type="checkbox"/> Last Chest x-ray – date:	<input type="checkbox"/> Unknown
	<input type="checkbox"/> QuantiFERON or T Spot Assay result and date:	<input type="checkbox"/> Past positive TB infection, course taken:
Is this the first dose?	<input type="checkbox"/> Yes – date of first dose: _____	<input type="checkbox"/> No – date of last dose: _____

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.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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: 713-983-4647

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