Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

MIRIKIZUMAB (OMVOH®) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
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 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:**

