ALLIED INFUSION SERVICES

# Omvoh (mirikizumab-mrkz) Order

Phone: 713-222-2364 or 1-888-538-0060
Fax: 832-698-3961

## Patient Information

Name: _____
DOB: _____
Address: _____
City: _____ State: _____
Zip: _____ Weight: _____
Phone: _____
Allergies: _____

## Prescriber Information

Prescriber Name: _____
NPI: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____

## Diagnosis (please provide ICD-10 code in space provided):

____ Ulcerative Colitis

____Other: _____

**Nursing Orders: Hold infusion and notify provider for:**

Signs/symptoms of illness or active infection, planned/recent surgical procedures, cough, night sweats, unintended weight loss, recent live vaccinations, active shingles.
If infusion related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated

## Premedications:

☐ Tylenol 650mg PO ☐ Loratadine 10mg PO ☐ Benadryl 25mg IV or PO ☐ Solu-Medrol 40mg, 125mg or ____ mg
☐ Other: _____

Order valid for one year unless otherwise indicated. IV solutions and diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

| | |
|---|---|
| OMVOH IV | ☐ Omvoh 300mg. Infuse IV over 30 minutes every 4 weeks x 3 doses (weeks 0, 4, 8)<br>☐ Other: _____<br>Mixed in 100 ml 0.9% sodium chloride or 100 ml - 250 ml D5W. |

Prescriber Name (Please print): _____
Prescriber Signature: _____ Date: _____

**Please include a copy of the latest insurance information as well as all applicable clinical notes.**
Email to: orders@alliedinfusion.com Fax to: 832-698-3961

By signing this form, you certify that the use of the selected treatment is medically necessary and you will be supervising the treatment of the patient. Additionally, you authorize Allied Infusion Services to act as your prior authorization designated agent when interacting with medical and prescription payors and patient assistance programs.