medix infusion

Omvoh® Order Form
(mirikizumab-mrkz)

FAX TO: 972.499.9210

Patient Information

Patient Name: ______________________ DOB: ________ Phone: ______________ Sex: M F Ht: _____ Wt: _____ lbs kg

Primary Language: ______________ Allergies: ______________________________

Patient Preferred Location: ______________________________

Diagnosis

ICD 10 Code Required

Moderate to Severe Crohn's Disease (K50.00-K50.919), ICD 10 ________________

Moderate to Severe Ulcerative Colitis (K51.00-K51.919), ICD 10 ________________

Infusion Orders

DOSE | DIRECTIONS | DURATION

(Crohn's Disease) 900mg IV at week 0,4, and 8

(Ulcerative Colitis) 300mg IV at week 0,4, and 8

Is patient currently receiving therapy above from another facility?

YES NO

If yes, Facility Name: ______________________

Date of last treatment: ______________________

PRE-MEDICATION ORDERS

LAB ORDERS

LFTs and Billirubin whould be monitored at baseline, during first 24 weeks of treatment, and periodically.

Lab Frequency: Prior to 4 and 8 week dose Other: ______________________

No premeds ordered at this time

Acetaminophen 650mg PO Other: ______________

Diphenhydramine 25mg PO

Methylprednisolone 40mg IVP

Labs to be drawn by: Medix Infusion Referring Physician

No labs ordered at this time

CBC q ________ CMP q ________ CRP q ________

ESR q ________ LFTs q ________ Other ________

Required Clinical Documentation

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

LAB AND TEST RESULTS

- Provide copy of negative TB result (QuntiFeron Gold, T-spot, PPD, TST, CXR) within 1 year of therapy initiation
- Provide copy of Liver Enzymes and Billirubin

PRIOR FAILED THERAPIES (including corticosteroids, antimalarials, NSAIDS, immunosuppressants)

Medication: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

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Prescriber Information

Prescriber Name: ______________________ Signature: ______________________

Date: ____________ NPI #: ______________ Specialty: ______________________

Supervising Physician: ______________________________________ (If Applicable)

Address: ______________________ City: ______________________ State: ________ Zip: ________

Contact Name: ______________ Phone: ______________ Fax: ______________ Email: ______________