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 _____

Medication Order

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

☐ Tylenol 650 mg PO

☐ Diphenhydramine 25 MG PO

☐ Diphenhydramine 25 MG IV

☐ Ceterizine 10 mg PO

☐ Famotidine 20 mg PO

☐ Methylprednisolone _____ mg

Lab Orders

LFTs and Bilirubin to be drawn prior to dose at weeks 4 and 8

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

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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Medix Infusion will collect necessary labs if not included in the referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____