

MIRIKIZUMAB (OMVOH™) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:		Date of Birth:	
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"/> 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 next dose due: _____	

Mirikizumab (OmvoH™) Prescription

Mirikizumab (OmvoH™) refill as directed x 1 year

Induction Dose: Infuse 300 mg IV over at least 30 minutes at Weeks 0, 4, and 8.

Maintenance Dose: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter.

Other: _____

After each infusion, the IV tubing will be flushed with NS 30ml using a 50ml bag.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

Yes No

Dosage:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ 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.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.

Implanted Port: NS 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.

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:

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