Local Infusion

MYLOCALINFUSION.COM

OMVOH (MIRIKIZUMAB-MRKZ) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments:_____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Moderate to severe active ulcerative colitis, ICD 10: K51._____
❑ Moderate to severe active Crohn's disease, ICD 10: K50._____
❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DIAGNOSIS	DOSE / FREQUENCY	ROUTE
Omvoh	❑ Ulcerative Colitis	Initial treatment: 300mg at week 0, 4, & 8 then Maintenance treatment: 200mg at week 12 and every 4 week	❑ IV ❑ SubQ
	❑ Crohns	Initial treatment: 900mg at week 0, 4, & 8 then Maintenance treatment: 300mg at week 12 and every 4 week	❑ IV ❑ SubQ

x3 IV infusions need to be completed prior to SubQ injections.
❑ Please check this box if you DO NOT want Local Infusion to complete insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS