

Mirikizumab-mrkz (Omvoh IV)

Provider Order Form rev. 2/20/2025

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Ulcerative Colitis: _____
Crohn's Disease: _____
Other: _____ Description: _____

THERAPY ADMINISTRATION & DOSING**For Ulcerative Colitis:**

- Administer mirikizumab-mrkz (Omvoh IV) 300mg IV over 30 mins

For Crohn's Disease:

- Administer mirikizumab-mrkz (Omvoh IV) 900mg IV over 90 mins
- Flush IV line after infusion with NS 0.9% or D5W, administer flush at the same rate as the Omvoh administration rate
- Only IV induction dosing will be provided. Subcutaneous dosing **WILL NOT** be provided

FREQUENCY

- Induction: week 0, week 4, and week 8

ADDITIONAL ORDERS**LABORATORY ORDERS**

- Other: _____

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

- Hold infusion and notify provider for:
- Positive TB test
 - Elevated LFTs
 - Signs or Symptoms of active infection
 - Signs or symptoms of hepatotoxicity
 - Recent live vaccine
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name (print)_____
Provider Signature_____
Date

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

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.