Mirikizumab-mrkz (Omvoh IV)

Provider Order Form rev. 2/20/2025

PATIENT INFORMATION

Referral 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

Required Labs: TB, LFTs, and Bilirubin levels prior to initiating treatment

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.