

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067



(OmvoH IV)

# mirikizumab-mrkz

Infusion orders

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**DIAGNOSIS** (and ICD 10 code)

Ulcerative Colitis ICD-10 Code: K51.90  
 Other Diagnosis: ICD-10 Code: \_\_\_\_\_

**NOTE**

**List Tried & Failed Therapies, including duration of treatment:**

1)  
2)

\*\*Referring physician is responsible for monitoring and reviewing the following labs prior to treatment:

- Fasting phosphorus level prior to each dose for first 3 doses and administer only if below ULN
- Fasting phosphorus level 2-4 weeks after dose modifications  
If dose adjustments are needed, new order must be sent by provider based on PI dose calculations

**MIRIKIZUMAB-MRKZ** (OmvoH IV) **ORDERS**

**Medication ordered**  
OmvoH 300 mg IV at weeks 0 , 4 , 8

**SPECIAL INSTRUCTIONS**

**PATIENT WEIGHT**  
\_\_\_\_\_ lbs.  
\_\_\_\_\_ kg

\*\*Hepatotoxicity in treatment of Crohn's disease. Drug induced liver injury during induction has been reported. Monitor LFT's and bilirubin at baseline and during induction, up to at least 24 weeks of treatment. Monitor thereafter according to routine patient management.

**REQUIRED DOCUMENTATION:**

This signed order form by the provider  
 Patient demographics AND insurance information  
 Clinical/Progress notes supporting primary dx  
 Confirmed negative TB testing  
 LFT and Bilirubin lab results

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_