

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



(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 _____