

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



(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

New Referral Referral Renewal Medication/Order Change Benefits Verification Only 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 _____