Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

(Omvoh IV)

mirikizumab-mrkz

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐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 _____