

# MIRIKIZUMAB (OMVOH™) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



<b>Patient Name:</b>	<b>Date of Birth:</b>			
<b>Address:</b>				
<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

## Clinical Information

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code:</b>
<b>TB Status:</b>	<input type="checkbox"/> PPD (negative) – date: _____ <input type="checkbox"/> Active TB <input type="checkbox"/> Last Chest x-ray – date: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Past positive TB infection, course taken: _____
<b>Is this the first dose?</b>	<input type="checkbox"/> Yes – date of first dose: _____ <input type="checkbox"/> No – date of next dose due: _____

## Mirikizumab (OmvoH™) Prescription

Mirikizumab (OmvoH™) refill as directed x 1 year

- Induction Dose: Infuse 300 mg IV over at least 30 minutes at Weeks 0, 4, and 8.
- Maintenance Dose: Infuse 200mg subcutaneously at week 12 and every 4 weeks thereafter.
- Other: \_\_\_\_\_

After each infusion, the IV tubing will be flushed with NS 30ml using a 50ml bag.

## Ancillary Orders

### Anaphylaxis Kit

If this is a 1<sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?

- Yes  No

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
  - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

### Medication Orders

- Other: \_\_\_\_\_

### IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

### Lab Orders

- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Prescriber Information

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

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