

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- | | |
|---|---|
| <input type="checkbox"/> K50.00 Crohn's Disease – small intestine | <input type="checkbox"/> K51.00 Universal Ulcerative Pancolitis–chronic |
| <input type="checkbox"/> K50.10 Crohn's Disease – large intestine | <input type="checkbox"/> K51.50 Left sided Ulcerative Colitis – chronic |
| <input type="checkbox"/> K50.80 Crohn's Disease – small & large intestine | <input type="checkbox"/> K51.80 Other Ulcerative Colitis – chronic |
| <input type="checkbox"/> K50.90 Crohn's Disease, unspecified | <input type="checkbox"/> K51.90 Ulcerative Colitis |
- ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Insurance Information | <input type="checkbox"/> List of Medications | <input type="checkbox"/> Tried & Failed Therapies | <input type="checkbox"/> Most Recent History & Physical | <input type="checkbox"/> Negative TB screening |
| <input type="checkbox"/> Baseline Liver Function Tests & Bilirubin | | | | |

MEDICATION ORDER

For Ulcerative Colitis

- Omvoh® (mirikizumab) 300 mg IV in 250 ml NS over 30 minutes at Week 0, Week 4 and Week 8
*Flush with 30 ml NS after each infusion

For Crohn's Disease

- Omvoh® (mirikizumab) 900 mg IV in 250 ml NS over 90 minutes at Week 0, Week 4 and Week 8
*Flush with 30 ml NS after each infusion

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

- Acetaminophen: 650 mg
 Cetirizine: 10 mg
 Diphenhydramine: 25 mg

IV

- Methylprednisolone: 125 mg
 Diphenhydramine: 25 mg

OTHER: _____ PO IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN